PENNSYLVANIA STATE SYSTEM OF HIGHER EDUCATION

ANNUITANT HEALTH CARE PROGRAM (AHCP) ENROLLMENT CHANGE FORM

REASON FOR COMPLETING THIS FORM (COMPLETED BY ANNUITANT)

☐ OPEN ENROLLMENT ☐ LIFE EVENT - ENROLL RETIREE/SPOUSE/DEPENDENTS ☐ LIFE EVENT - REMOVE SPOUSE/DEPENDENTS

PROVIDE ADDITIONAL DETAILS IN REMARKS SECTION BELOW

If looking to terminate your AHCP coverage, you need to complete a different form found here - https://www.passhe.edu/hr/benefits/retirees/documents/cancel-ahcp.pdf

INTERNAL INFORMATION (COMPLETED BY SYSTEM OFFICE)

PERSONNEL # MONTHLY PREMIUM INIT. PREMIUM (IF DIFFERENT)

AHCP EFFECTIVE DATE

PAY TYPE ☐ Auto Debit ☐ Via SERS

ANNUITANT INFORMATION(COMPLETED BY RETIREE)

ANNUITANT NAME HOME PH #

BIRTH DATE CELL PH #:

SOCIAL SECURITY # PERSONAL EMAIL ADDRESS
**All communications will be sent via email, if provided.*

STREET ADDRESS	CITY	STATE	ZIP CODE COUNTY

NOTE 1: Any Medicare-eligible retiree/dependent is required to enroll in Medicare Part A and Medicare Part B in order to be enrolled in Annuitant Health Care Coverage. Please provide a copy of your Medicare ID card.

Retiree's Medicare Insurance #

Med. Part A Eff. Date Med. Part B Eff. Date

NOTE 2: The System Office will confirm that a $10,000 lifetime annuity was established with your State System retirement plan prior to your enrollment. If your retirement plan was ARP/PSERS, you are required to complete the banking form: **https://www.passhe.edu/hr/benefits/retirees/documents/autodebit-banking-form.pdf**

DEPENDENTS COVERED UNDER MY ANNUITANT HEALTHCARE DATA (COMPLETED BY EMPLOYEE / ANNUITANT)

	DEPENDENT 1	DEPENDENT 2	DEPENDENT 3	DEPENDENT 4	DEPENDENT 5
GENDER	☐ Male ☐ Female ☐ Other	☐ Male ☐ Female ☐ Other	☐ Male ☐ Female ☐ Other	☐ Male ☐ Female ☐ Other	☐ Male ☐ Female ☐ Other
RELATIONSHIP	***Valid relationships types: spouse, child, stepchild, foster child, legal dependent; other than spouse, all other dependents age 19 - 25 must be full time students***				
NAME (Last, First, MI)					
DATE OF BIRTH					
SOCIAL SECURITY #					
DEP. MEDICARE INS #					
MEDICARE EFF. DATES (If applicable)	PART A: PART B:	PART A: PART B:	PART A: PART B:	PART A: PART B:	PART A: PART B:
HAS OTHER HEALTH INSURANCE?	☐ Yes, provide info. in remarks below	☐ Yes, provide info. in remarks below	☐ Yes, provide info. in remarks below	☐ Yes, provide info. in remarks below	☐ Yes, provide info. in remarks below

HEALTH CARE COVERAGE INFORMATION

NOTE 3: You will be enrolled in the AHCP health care coverage in which you are eligible based upon your bargaining unit, retirement date, and Medicare eligibility.

For mid-month qualifying life events in which Medicare-eligible retiree/spouse/dependents are being added, interim AHCP coverage may be used until the the start of the next calendar month to start the Freedom Blue PPO Medicare Advantage plan. The Freedom Blue PPO plan adheres to rules established by Centers for Medicare and Medicare Services (CMS) regarding when coverage may begin. The Freedom Blue PPO plan coverage only begins on the start of a calendar month. Retirees will be charged for the applicable AHPC premiums based upon their health care coverage tier.

For qualifying life events in which Medicare-eligible spouse/dependents are removed, there are CMS rules regarding advanced notice provided prior to the Freedom Blue PPO coverage is terminated. Also, coverage may only be ended on the end of a calendar month for those enrolled in the Freedom Blue PPO plan. As a result the applicable AHCP premiums will continue for any Freedom Blue PPO coverage provided by the Annuitant Health Care Program.

REMARKS:

AUTHORIZATION FOR APPLICATION FOR ENROLLMENT: I request the above enrollment change for insurance coverage in the Annuitant Health Care Program. *I understand no changes can be made to this coverage except during the Annuitant Health Care Open Enrollment in November of each year , or when a qualified life event occurs.* I also understand this application is subject to approval by the Plans, and my coverage will be subject to the terms of the agreement issued to the Pennsylvania State System of Higher Education Health Care Programs. Any person or operation having provided or who may provide health care services to me or any person named on this application either prior to or during this contract is authorized to furnish to the Plans any information or records relating to these services. Any person who knowingly and with intent to defraud any insurance company or other person who files an application for insurance or statement or claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. *I understand I may be personally liable for any claims paid on behalf of an ineligible dependent.*

ANNUITANT SIGNATURE	DATE (MM/DD/YYYY)	

The following categories of individuals may be eligible for coverage under the State System Annuitant Health Care Program:

- Legal Spouse
- Unmarried Dependent child under 19 years of age who meets one of the following requirements:
  - A natural child of your own
  - A legally adopted child (including a child living with you during the probation period)
  - A stepchild living with you
  - A child who is living with and being solely supported by you and for whom you are the legal guardian
  - A foster child, if you were the child's legal guardian, or foster parent prior to the child's 18th birthday (foster children under age 18 are not eligible dependents)
  - A child being supported by you under a court order as a result of a divorce decree
  - A newborn child of yours from the moment of birth to a maximum of 31 days from date of birth. To be covered as a Dependent beyond the 31-day period, the newborn child must be added as a Dependent through the Annuitant Health Care Program office (717) 720-4153
  - Unmarried dependent child 19 to 25 years of age who meets all of the following requirements:
    - Enrolled in and attending as a full-time student at a recognized course of study or training;
    - Not employed on a regular full-time basis; and
    - Not covered under any group insurance plan or prepayment plan through the student's employer.
  - Unmarried Dependent child 19 years of age or older who is incapable of self-support because of a physical or mental disability that commenced before the age of 19.

When Can I Make Changes To My Covered Dependents?

Outside of open enrollment, if you experience a qualifying life event you may have the opportunity to add or remove dependents from your coverage, or make other changes to your benefit elections. You will need to notify the Annuitant Health Care Program office at (717) 720-4153 within **60 days** of the event occurring. Below are some of the more common examples.

- **Removing Dependents**

  You are required to contact the Annuitant Health Care Program office (717) 720-4160 and remove a dependent who is no longer eligible for State System insurance coverage under the following situations:
  - Covered child attains age 19 and is not a full-time student (as designated above) (unless disabled)
  - Covered child attains age 25 (unless disabled)
  - Divorce (removal of spouse and stepchildren)
  - Death of a dependent

- **Adding Eligible Dependents**

  You may add a dependent to your health care coverage due to a qualifying life event. You must notify the Annuitant Health Care Program office (717) 720-4160 and submit the enrollment change form within **60 days** of the qualifying life event.
  - You gain a dependent through birth or adoption
  - You get married
  - Your dependent loses coverage under another employer's plan
  - Your dependent loses eligibility for coverage in a Medicare plan, a Medicaid plan or a state children's health insurance program

- **Other Plan Enrollment Changes**

  You must notify the Annuitant Health Care Program office at (717) 720-4160 and submit the enrollment change form within **60 days** of the qualifying life event.
  - You lose coverage under your spouse's plan
  - You are enrolled in a plan option that is no longer available, or is substantially reduced

ENROLLMENT IN MEDICARE PARTS A AND B IS REQUIRED FOR YOU AND YOUR SPOUSE IF YOU RETIRED AFTER JANUARY 1, 1999.