

EMPLOYEE ENROLLMENT/CHANGE FORM

Important: Changes made on this form will affect your medical and supplemental benefits.

Section 1: Employee Data					
Social Security #	Title <input type="checkbox"/> Mr. <input type="checkbox"/> Dr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Name (Last Plus Suffix, First, MI)		Employee #	
Street Address		City/State/Zip		County Name	
Mailing Address (if different than address listed above)		City/State/Zip		County Name	
Home Phone # ()	Work Phone # ()	Cell Phone # ()	Date of Birth (mm/dd/yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Relationship Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Common Law			Date of Marriage/Domestic Partnership		
Are you covered by another medical plan? <input type="checkbox"/> Yes <input type="checkbox"/> No			Do you have Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Section 2: Enrollment Information (Please indicate all reasons for enrollment change – you may mark more than 1 box)					
Action Requested:		Enrollment/Change Effective Date: _____			
<input type="checkbox"/> New Enrollment <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Add Dependent(s) <input type="checkbox"/> Remove Dependent(s) <input type="checkbox"/> Plan Change					
Event: <input type="checkbox"/> Marriage <input type="checkbox"/> Birth/adoption of child <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Termination of Benefits <input type="checkbox"/> Address Change <input type="checkbox"/> Other (Reason): _____					Date of Event: (if applicable) _____
Section 3: Medical Plan Option (Select one)					
<input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> CDHP <input type="checkbox"/> Decline					
Medical Plan Name		Health Care Center or Dr. Name (required for HMO)		Health Care Center/Dr. ID #	
Are you currently a patient of this practice? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Section 4: Supplemental Benefits (Includes prescription drug, dental, vision and hearing aid coverage)					
<input type="checkbox"/> Decline Note: Supplemental benefits are not effective for first six months of employment.					
Section 5: Dependent Data					
<i>Complete this section if adding or removing dependents. If adding a new dependent, you must present additional documentation such as a marriage certificate or birth certificate to your local HR office or your supervisor.</i>					
HR Initial Eligibility Doc Verified	Name (Last, First, MI)	Dependent Social Security #	Date of Birth (mm/dd/yyyy)	Add or Remove	Health Care Center/Doctor Name or ID # for HMO Only (if different than the employee)
	Spouse/Domestic Partner			<input type="checkbox"/> Add <input type="checkbox"/> Remove	Currently a patient of this practice? <input type="checkbox"/> Yes <input type="checkbox"/> No
List address and telephone number if different than the employee:					
Is your spouse/domestic partner: A commonwealth employee/retiree? <input type="checkbox"/> Yes <input type="checkbox"/> No Covered by another medical plan? <input type="checkbox"/> Yes <input type="checkbox"/> No Covered by Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No					
My spouse/domestic partner is currently: <input type="checkbox"/> Not employed <input type="checkbox"/> Employed with health coverage <input type="checkbox"/> Self Employed <input type="checkbox"/> Employed with no health coverage					
If your spouse/domestic partner is employed, please complete the following: Does the employer offer a group health plan? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the plan offered at a cost or is there financial incentive to decline coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No					

Continued on second page

Section 5: Dependent Data (continued) – Complete second form if you have additional dependents

HR Initial Eligibility Doc Verified	Name (Last, First, MI)	Dependent Social Security #	Date of Birth (mm/dd/yyyy)	Add or Remove	Health Care Center/Doctor Name or ID # for HMO Only (if different than the employee)
Dependent #1	<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other Explain relationship			<input type="checkbox"/> Add <input type="checkbox"/> Remove	Currently a patient of this practice?
	Name _____				<input type="checkbox"/> Yes <input type="checkbox"/> No

List address and telephone number if different than the employee:

Is dependent covered by another medical plan? Yes No Does dependent have Medicare? Yes No

If the above-listed dependent is between the ages of 19 and 26, is your dependent eligible for other employer sponsored health coverage (other than through a parent)? Yes No

Dependent #2	<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other Explain relationship			<input type="checkbox"/> Add <input type="checkbox"/> Remove	Currently a patient of this practice?
	Name _____				<input type="checkbox"/> Yes <input type="checkbox"/> No

List address and telephone number if different than the employee:

Is dependent covered by another medical plan? Yes No Does dependent have Medicare? Yes No

If the above-listed dependent is between the ages of 19 and 26, is your dependent eligible for other employer sponsored health coverage (other than through a parent)? Yes No

Dependent #3	<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other Explain relationship			<input type="checkbox"/> Add <input type="checkbox"/> Remove	Currently a patient of this practice?
	Name _____				<input type="checkbox"/> Yes <input type="checkbox"/> No

List address and telephone number if different than the employee:

Is dependent covered by another medical plan? Yes No Does dependent have Medicare? Yes No

If the above-listed dependent is between the ages of 19 and 26, is your dependent eligible for other employer sponsored health coverage (other than through a parent)? Yes No

Employee Agreement and Signature:

“I certify that the information entered on this form is true and complete and that I agree to all of the Terms and Conditions listed on the next page of this form and in the PEBTF Summary Plan Description and Plan Document.”

Employee Signature	Date
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Section 6: Commonwealth Data (to be completed by HR Service Center or HR Office)

Position #	PEBTF Group #	PEBTF Sub Group	Plan Code	County Code	
Current Service Date	Dept. Code	Barg. Unit	Org Code	SAP EEP	SAP ESG

Section 7: HR Remarks

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HR Service Center or HR Office Signature	Date Enrollment Form Received	Date Enrollment Form Processed
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TERMS AND CONDITIONS

1. I hereby apply to enroll (or change) medical and/or supplemental coverage in the Pennsylvania Employees Benefit Trust Fund ("Plan") for me and/or my dependents (as defined in the Plan) and declare that the foregoing information is true and correct to the best of my knowledge and belief. I understand that eligibility for coverage and payment of benefits under the Plan in all instances is subject to the terms of the Plan and that any false or misleading information that I provide to the Plan regarding the status of any dependent and any other medical or supplemental coverage that may be applicable may result in the suspension or termination of coverage under the Plan and may require the repayment to the Plan of any benefits paid under the Plan, in addition to the imposition of criminal and civil penalties. I understand that I must inform the Plan of any changes in the employment status of any dependents which may affect their eligibility under the Plan and that my failure to do so may result in the loss of coverage, repayment of any amounts paid on their behalf, in addition to the imposition of criminal and civil penalties.
2. I authorize any payroll deduction relating to my share of the cost of such coverage and understand that such deductions will be made on a pre-tax basis to the extent permitted by law.
3. I further understand that the Plan has the right to subrogate, on my behalf and on behalf of any dependent, against any third parties or others obligated to pay any claims which the Plan has paid or may pay. I agree that I will direct any attorney that I may retain to satisfy such subrogation interest in full prior to receipt by me or my dependents of any recovery to which I and/or my dependents may be entitled and to otherwise fully cooperate with the Plan regarding all subrogation matters.
4. I further understand that the Plan includes a coordination of benefits provision and agree to fully cooperate with the Plan regarding all coordination of benefit matters. I acknowledge that in the event the Plan concludes that I have provided any false or misleading information, or failed to appropriately cooperate with the Plan, regarding any subrogation or coordination of benefit matters, the Plan may suspend or terminate my coverage or my dependents' coverage under the Plan and take such other action as it deems appropriate.

INSTRUCTIONS FOR COMPLETING EMPLOYEE ENROLLMENT/CHANGE FORM

Listed below are instructions for completing the Employee Enrollment/Change Form. You will see that each section on the form contains a number. Instructions for completing each section appear below.

Prior to selecting your medical plan, make sure that you review your Summary Plan Description (SPD). You may visit the PEBTF website, www.pebtf.org to view the SPD and to link to the medical plans. You will be able to search for network providers on each medical plan's site. Contact the PEBTF at 1-800-522-7279 with questions regarding your benefits. If you have questions about completing this form, contact the HR Service Center or your local HR office if your agency is not served by the HR Service Center.

TO COMPLETE THIS FORM ONLINE, YOU MUST HAVE ADOBE 4.0 OR HIGHER COMPLETE EACH SECTION OF THE FORM UTILIZING THE "HAND TOOL" IN THE ADOBE ACROBAT PROGRAM

After you have completed the form, submit the form to the HR Service Center or your local HR office if your agency is not served by the HR Service Center.

Refer to Corresponding Sections on the Enrollment Form

- (1) This section is to be completed by the employee.
- (2) This section is to be completed by the employee. Indicate the reason(s) for completing the enrollment form. If it is due to a qualifying life event, please list the date of the event as well as the effective date for coverage. Qualifying life events include but are not limited to: Marriage, birth or adoption, divorce, dependent gains or loses coverage under another health plan, employee relocates and is no longer eligible for his/her current plan, cost of coverage of a plan option changes significantly or plan option is no longer available.
- (3) This section is to be completed by the employee. Please indicate the medical plan option. If you are choosing an HMO, you must complete the primary care physician information under Health Care Center. The ID # can be found on the health plan's website under the provider search. If you don't have the ID #, please make sure you include the doctor's full name. Also, if you are not currently a patient of the medical practice, call the doctor's office to confirm they are accepting new patients.
- (4) This section is to be completed by the employee. If you enroll in medical coverage, you will be automatically enrolled in Supplemental Benefits (prescription drug, dental, vision and hearing aid coverage) after your first six months of employment. If you do not want to be enrolled in Supplemental Benefits, indicate by checking "Decline."
- (5) This section is to be completed by the employee. Please list the dependents that will be enrolled in PEBTF benefits and answer all questions. Your spouse/domestic partner and dependents must enroll in the same plan in which you are enrolled. You will need to present documentation verifying the eligibility status for the dependents included on this enrollment form. It is your responsibility to advise the HR Service Center or your local HR office if your agency is not served by the HR Service Center of any changes to your dependent's eligibility status.

Employees hired on or after August 1, 2003: Your spouse/domestic partner must accept his or her employer's medical or supplemental benefits even if there is a required employee contribution or a monetary incentive to decline. Your spouse/domestic partner's coverage under the PEBTF is secondary to his or her employer's coverage.

Employees hired prior to August 1, 2003: Your spouse/domestic partner may enroll in PEBTF benefits as primary coverage if his or her employer's coverage is offered at a cost or if there is a monetary incentive to decline. If your spouse keeps his or her employer's coverage, PEBTF coverage under the PEBTF is secondary.

Dependent Children: Your child age 19 to age 26 is eligible for coverage, provided your child is not eligible for coverage under another employer-sponsored health plan (does not include coverage through a parent). Only eligible children to age 26 should be included on this enrollment form.

NOTE: Eligibility for coverage for dependents to age 26 is subject to periodic evaluation and recertification. Should dependent eligibility or any other information on this enrollment form change at any time, eligibility for coverage may be reconsidered by the PEBTF.

Please sign and date the form. Submit the form to the HR Service Center or your local HR office if your agency is not served by the HR Service Center.

- (6) Do not write in this section. This section is for HR Service Center or HR Office use only.
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