PennState
Human Resources

Retiree Request for Change of Healthcare

See reverse side regarding important information

Retiree Name – Please Print _____ PSU ID # _____

Date of Birth ____/____/____ Home Phone (____) ____-____

Home Address _____

_____

Eligible dependents are defined as a spouse and children up to the age of 26. Dependent coverage under the medical plan may apply to spouse only, child(ren) only, or to a spouse and child(ren). If dependent coverage is requested more than 31 days after acquiring the dependent(s), the coverage will become effective the date the form is received in the Employee Benefits Division. Description of eligible dependents: https://ohr.psu.edu/benefits/eligible-dependents/

If adding dependent(s), was/were dependent(s) acquired within the past 31 days?

- ☐ Yes
- ☐ No

If yes, date acquired: ____/____/____

Reason for Change:

- ☐ Adoption
- ☐ Deceased
- ☐ Dependent Child Age 26
- ☐ Divorce
- ☐ Loss of Coverage
- ☐ Marriage
- ☐ Newborn
- ☐ Other Coverage
- ☐ Step Child(ren) No Longer Eligible
- ☐ Other – Reason Not Listed

If reason for change is due to Loss of Coverage, you must also provide a copy of benefit plan cancellation from former employer or former insurance carrier.

Effective date of change: ____/____/____

Retiree Healthcare Coverage

My choice for Retiree Healthcare Coverage is:

- ☐ **NO COVERAGE**
- ☐ Retiree Only
- ☐ Retiree and Spouse
- ☐ Retiree and Child(ren)
- ☐ Retiree, Spouse, and Child(ren

Employee Benefits Division, James M. Elliott Building, University Park, PA 16802
Service Center: (814) 865-1473, Fax: (814) 865-6820
E-mail: benefits@psu.edu, Website: http://ohr.psu.edu/benefits

Please complete section below to add or remove a dependent on your coverage:

ADD or DELETE	Full Name (Last, First, MI)	Sex	Relationship	Birthdate	Student or Disabled	SSN
A / D		M / F	Self		S / D	
A / D		M / F			S / D	
A / D		M / F			S / D	
A / D		M / F			S / D	
A / D		M / F			S / D	
A / D		M / F			S / D	
A / D		M / F			S / D	

Other Insurance	**Do you or your covered dependent(s) have other healthcare coverage? NO _____ If YES, complete the following:**		
List all family members with other healthcare coverage, in addition to coverage through Penn State:			
Policy Holder	Employer	Insurance Company	
List dependents covered by Policy		Effective date of Policy	Contract or I.D. #

Do you or your dependent(s) have Medicare coverage? NO _____ YES _____			
Name	Medicare Claim No.	Part A Effective Date	Part B Effective Date
Name	Medicare Claim No.	Part A Effective Date	Part B Effective Date

****CAUTION**** If you refuse the retiree healthcare coverage for yourself, you will not be permitted to enroll in the retiree healthcare plan through Penn State on a future date.

_____ _____/_____/_____

Retiree Signature Date Signed

Mail or FAX completed form to:

EMPLOYEE BENEFITS DIVISION
James M. Elliott Building, 4th Floor
University Park, PA 16802
FAX: 814-865-6820