PSU ID# or SSN: _____

HIGHMARK. | Freedom Blue PPO

Former Employer Complete This Section	
Employer's Signature and Date:	Effective Date:

I am the ☐ RETIREE of PSU ☐ SPOUSE of Retiree

TO ENROLL IN FREEDOM BLUE PPO, PLEASE PROVIDE THE FOLLOWING INFORMATION:

First Name | Middle Initial (if applicable) | Last Name | Suffix | Sex ☐ Male ☐ Female

Home Address (No P.O. Boxes) | Apt# | City | State | Zip | County

Mailing Address (P.O. Boxes allowed) | Apt# | City | State | Zip | Date of Birth ___/___/___

Home Phone (with area code) ( )

Email Address (if applicable)

PLEASE PROVIDE YOUR MEDICARE INSURANCE INFORMATION:

Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card.

~~-OR-~~

- ~~Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.~~

Medicare Health Insurance

SAMPLE ONLY

Name _____

Medicare Claim Number _____ Sex _____

__ __ __ — __ __ — __ __ __ __ __

Is Entitled To Effective Date

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

You must have Medicare Part A & Part B to join a Medicare Advantage Plan.

Please fill in sample above with Medicare Information

YOU WANT TO ENROLL IN:

☒ 178428

The Pennsylvania State University

OTHER INSURANCE

1. Are you currently enrolled in a non-Medicare Highmark Blue Shield health plan? ..... Yes ☐ No ☐

   If YES, name of plan: _____

2. Will either you or your spouse be employed once enrolled in Freedom Blue PPO? Self: .....Yes ☐ No ☐
   Spouse: ...Yes ☐ No ☐

   Your Retirement Date (Month/Day/Year):_____ Spouse's Retirement Date (Month/Day/Year):_____

3. Will you have any Health Insurance and/or Prescription Drug Coverage other than Freedom Blue PPO or Medicare that will continue after your enrollment? .....Yes ☐ No ☐

If YES, please complete the enclosed "Other Insurance Addendum" and return with your completed application.

READ AND ANSWER THESE IMPORTANT QUESTIONS

Please choose the name of a Primary Care Provider (PCP), clinic or health center.

Name of Provider (recommended) ~Information Not Necessary	PCP/NPI # ~Information Not Necessary (from the enclosed Provider Directory)

The Freedom Blue PPO provider directory is available in a CD-ROM format for your computer. Please check here to receive your provider directory in CD-ROM.

Are you currently enrolled in another Medicare Advantage plan? *(Confirmed enrollment in Freedom Blue PPO means you will be automatically disenrolled from your current Medicare Advantage plan.)* ..... Yes ☐ No ☐

Do you have End-Stage Renal Disease? ..... Yes ☐ No ☐
If YES, then you are not eligible to enroll UNLESS you are already a non-Medicare Highmark Blue Shield member or enrolled with ESRD in a Medicare Advantage plan that has withdrawn from your coverage area. If you have had a successful kidney transplant and/or you don't need regular dialysis any more, please attach a note or records from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

Are you enrolled in your State Medicaid program? ..... Yes ☐ No ☐
If "YES," please provide your Medicaid Number: _____

Are you a resident in a long term care facility such as a nursing home? ..... Yes ☐ No ☐
If "YES," please provide the following information:

Name of Institution: _____

Address and Phone Number of Institution (number and street): _____

STOP! **You may belong to an employer group or trust fund health plan whose drug coverage is as good as or better than standard Medicare Prescription Drug Coverage (Part D). It is important that you consider your decision to enroll in our plan carefully. In order to finalize your request for enrollment in our plan, we need you to confirm that you want to be enrolled in this group sponsored plan by signing below.**

READ AND SIGN BELOW

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by Freedom Blue PPO or by Medicare.

Signature	Today's Date

If you are the authorized representative, you must sign above and provide the following information:

Name: _____ Phone Number: _____

Address: _____ Relationship to Enrollee: _____

Please return the top copy of both pages of this form and keep the bottom copies for your records.

Please maintain a copy for your files and send original to Penn State Employee Benefits:

Employee Benefits
The 331 Building, Suite 136
University Park, PA 16802