Retiree Request for Change of Healthcare Form

Please note: Changes will be made effective the 1st of the following month from the receipt date of this signed and dated form.

Retiree Name – Please Print

PSU ID #

Date of Birth

Home Phone

Home Address

Retiree Healthcare Coverage:

My choice for Healthcare Coverage is:

☐ NO COVERAGE

*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 at a future date*

☐ Retiree Only

☐ Retiree and Spouse

☐ Retiree and Child(Children)

☐ Retiree and Family

Adding a Dependent to Healthcare Coverage:

Retiree dependent coverage can be added only if the eligible dependent experiences an IRS qualifying life event change. Changes must be requested within 31 days of the event. The following are examples of IRS-defined life event changes:

- Employee's legal marital status changes, due to marriage, divorce, legal separation, or the death of a spouse;
- Changes in employment status of a spouse, which can include the ending of their employment, new or different working hours resulting in a change of their employer-sponsored benefits.
  - *If reason for change is due to Loss of Coverage, you must also provide a copy of benefit plan cancellation from the former employer or former insurance carrier.*

Eligible dependents are defined as a spouse, children up to the age of 26, or disabled children as certified by the insurance carrier. Dependent coverage under the healthcare plan may apply to retiree and spouse, retiree and child(ren), or retiree and family.

Description of eligible dependents: https://ohr.psu.edu/benefits/eligible-dependents.

If adding dependent(s) that will be enrolled in Aetna in which the retiree and/or no other dependent(s) are currently enrolled in, please select the applicable plan below. If a retiree and/or dependent(S) are currently enrolled in Aetna, you cannot change plans at this time. For information regarding the plan options, please visit: https://hr.psu.edu/retiree/benefits.

☐ Retiree PPO Plan

☐ Retiree PPO Savings Plan

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 (provide explanation below)
Adding a Dependent to Coverage

Effective date of change (date of the event): ______/______/______

Removing a Dependent from Coverage:

Effective date of change: ______/______/______

Please list all eligible members you are making a change for healthcare, dental, and/or vision

<table>
<thead>
<tr>
<th>Add or Remove</th>
<th>Full Name (Last, First, MI)</th>
<th>Sex</th>
<th>Relationship</th>
<th>Birthdate</th>
<th>Disabled?</th>
<th>Social Security #</th>
</tr>
</thead>
<tbody>
<tr>
<td>A / R</td>
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<td>M / F</td>
<td>Self</td>
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<td>Y / N</td>
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<td>Y / N</td>
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</tr>
</tbody>
</table>

Do you or your dependent(s) have Medicare coverage?** NO _____ YES ______

<table>
<thead>
<tr>
<th>Name</th>
<th>Medicare Claim No.</th>
<th>Part A Effective Date</th>
<th>Part B Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Medicare Claim No.</td>
<td>Part A Effective Date</td>
<td>Part B Effective Date</td>
</tr>
</tbody>
</table>

**If you and/or dependent(s) are Medicare eligible, an additional application for Freedom Blue is required. The application must be mailed with this form along with a copy of the Medicare card to reflect Part A and B information. Application: [https://hr.psu.edu/sites/hr/files/FreedomBlueApplication.pdf](https://hr.psu.edu/sites/hr/files/FreedomBlueApplication.pdf)

Consent for Healthcare Coverage Enrollment and Billing

I hereby accept the forms of insurance coverage contracted for by the University in the amounts for which I am or may become eligible or elect under the retiree healthcare coverage. I understand that I will be billed for my enrollment in the retiree healthcare coverage and that I am responsible for timely payment.

_________________________________________  ______/______/______
Signature  Date Signed

Mail or FAX completed form to:

PENN STATE EMPLOYEE BENEFITS
The 331 Building, Suite 136
University Park, PA 16802
FAX: 814-863-6227