PennState Human Resources

Retiree Request for Change of Healthcare and/or Tuition Discount 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

Plan:

☐ Retiree PPO Plan ☐ Retiree PPO Savings Plan

If switching medical plans upon retirement, any prior deductible or coinsurance amounts WILL NOT transfer to your new plan enrollment.

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)

_____

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Adding a Dependent to Healthcare Coverage or Tuition Discount Benefits

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

Removing a Dependent from Healthcare Coverage or Tuition Discount Benefits

Effective date of change: _____/_____/_____

Please list all eligible members you are making a change for healthcare, dental, and/or vision, or tuition discount						
Add or Remove	**Full Name (Last, First, MI)**	**Sex**	**Relationship**	**Birthdate**	**Medical/ Tuition Discount (Circle all that apply)**	**Disabled?**
A / R		M / F	Self		M / TD	Y / N
A / R		M / F			M / TD	Y / N
A / R		M / F			M / TD	Y / N
A / R		M / F			M / TD	Y / N
A / R		M / F			M / TD	Y / N
A / R		M / F			M / TD	Y / N

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

**If you are adding a newly eligible dependent and 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

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:

PLEASE CONTACT HR SERVICES AT 814-865-1473 TO PROVIDE YOUR DEPENDENT(S) SOCIAL SECURITY NUMBER(S) AS REQUIRED TO PROCESS YOUR BENEFITS

Penn State Employee Benefits, The 331 Building, Suite 136, University Park, PA 16802
Benefits Fax: (814) 863-6227
HR Services: (814) 865-1473