



VRP Retiree Request for Change of Healthcare – Retirement Date 6/30/17
All Changes Effective July 1, 2017

Employee/Retiree Name – Please Print

PSU ID #

Preferred Email

My choice for Retiree Healthcare Coverage is:

- | | |
|---|--|
| <input type="checkbox"/> NO COVERAGE | |
| <input type="checkbox"/> Retiree Only | <input type="checkbox"/> Retiree and Child(ren) |
| <input type="checkbox"/> Retiree and Spouse | <input type="checkbox"/> Retiree, Spouse, and Child(ren) |

Change to Health Plan:

- PPO Blue plan**
- PPO Savings plan with Health Savings Account** (please note: Penn State contributions do not apply to Retiree HSA accounts; any contributions you choose to make will be made either through the Highmark website or directly to Bank of America)

If Adding or Removing Spouse and/or Dependents:

Your retirement constitutes a Qualifying Event, so you are able to add or remove a spouse or dependents without loss of other coverage at this time. If you are adding a spouse or dependents, you will receive Dependent Verification information from Aon Hewitt in January 2017. Please be sure to complete this process in order to ensure continued coverage for the newly-added spouse or dependent.

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/>



PennState

Human Resources

Please complete section below to add or remove a spouse and/or 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	

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

Employee/Retiree Signature

_____/_____/_____
Date Signed

Any questions regarding this form should be directed to VRP2016@psu.edu

Mail or FAX completed form to:

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