2014 PEBTF Open Enrollment Form for REHP Members

This form should be completed **ONLY** if you are changing Health Benefit Options and you are **not Medicare eligible**. All other changes must be reported to your local Retirement Counseling Office. To verify whether your current Physician participates with a certain HMO or to obtain a Primary Care Physician's number, consult the respective plan's Provider Directory. **Non-Medicare eligible retirees and all non-Medicare eligible dependents must choose the same Health Plan. Medicare eligible annuitants and dependents cannot enroll in these plans.**

If you are changing health plans, please complete all sections.

Retiree Data

Social Security Number	Retiree Name (First, MI, Last)		Date of Birth
Street Address	City	State	Zip
County of Residence	Home Telephone Number	Open Enrollment Effective Date 01/01/15	

☐ This is a new address

All non-Medicare eligible dependents currently on your REHP coverage will be moved to the new plan that you select effective 1/1/15

Indicate the non-Medicare health plan option below.

☐ PPO Option	☐ Highmark PPO ☐ Aetna PPO (Open Choice) -- Western PA Only	
☐ HMO Option	☐ Aetna HMO ☐ Geisinger Health Plan HMO ☐ Keystone Health Plan Central HMO ☐ Keystone Health Plan West HMO	If enrolling in the HMO Option. List Primary Physician Name or Number (refer to the HMO's provider directory or online directory for this information)
☐ CDHP Option (retired on or after 7/1/04) - UnitedHealthcare CDHP		
☐ Basic Option (retired prior to 7/1/04)		

Authorization for application for Open Enrollment Change - I request and apply for enrollment for health insurance coverage and authorize deductions from my annuity, if applicable. I understand this application will be submitted and is subject to approval by the Plan or the PEBTF providing this health benefit coverage and will be subject to the terms of the agreement between the Commonwealth and such Plan or the PEBTF. Any person or organization that has provided health related services to me or to any of my dependents named on this application, either prior to or during, agree that the Plan or the PEBTF shall have all legal rights to subrogation on my behalf and/or the behalf of my dependents for recovery against third parties and/or other providers to pay such claims. Any additional documents required for release of any such information or records, or subrogation, will be promptly signed by me and/or my dependents.

_____ Signature

_____ Date

Please complete and return this form to the PEBTF postmarked by November 7, 2014.

PEBTF, 150 South 43rd Street, Suite 1, Harrisburg, PA 17111-5700 (717) 561-4750 or 1-800-522-7279