INSTRUCTIONS FOR COMPLETING EMPLOYEE ENROLLMENT/CHANGE FORM

Listed below are easy-to-understand instructions for completing the Employee Enrollment/Change Form. You will see that each section on the front of the form contains a number. Instructions for completing each section appear below.

Prior to making your Health Benefit Coverage selection, make sure that you review your Summary Plan Description. Your local Human Resource Office will provide marketing materials/provider directories of the managed care plans offered in your area, or the telephone numbers of the plans for you to request that material. These materials will help you to make the important decision of which health plan to choose. Any questions regarding your benefits or the completion of this form can be directed to your local Human Resource Office.

Refer to Corresponding Sections on the Front of the Enrollment/Change Form

PLEASE PRINT USING A BALL POINT PEN — PRESS HARD, YOU ARE MAKING MULTIPLE COPIES

(1) This section is to be completed by your local Human Resource Office.

(2) This section is to be completed by the employee.

(3) Please indicate the type of Medical Plan you are enrolling in by marking the appropriate box. If you are electing either the HMO or POS Option, you must record (in the boxes below) the name of the health care plan (for example: Keystone Health Plan Central) and the Health Care Center/Dr name. Also, if available, record the Health Care Center/Dr ID number (information can be found in the provider directory of the Health Care Plan selected). Provider directories can be obtained from either your local Human Resource Office or by contacting the Health Care Plans directly. Please answer the question, "Are you currently a patient of this practice?"

(4) Please indicate the Dental Option you would like to enroll in.

(5) If you elect Concordia Plus as your Dental Option, you must select a primary dental office. Your dependents may also elect a different primary dental office. If a different office is selected, please add the dependent(s) dental office in Section 8 under Health Care Center/Doctor name or ID#. If Delta Dental is elected, you do not have to complete this section.

(6) This section is for employee demographic information. Please complete all of the applicable information in this section except for the section titled "CTY CODE" (your Human Resource Office will complete this section for you).

(7) Do not complete this section. Your Human Resource Office will complete it for you.

(8) Please complete all of the applicable information in this section. Your Human Resource Officer will initial in the Eligibility Doc. Verified column after viewing your dependent documentation.

(9) Do not write in this section. This section is for Human Resource Office use only.

(10) Please sign form.

(11) Please record the date of your signature.

(12) Do not write in this section. This section is for Human Resource Office use only. Human Resource Staff must sign the form and all information must be completed. Once the form is completed and signed, Human Resource Staff should forward a copy to the employee for his/her records.

PEBTF

EMPLOYEE ENROLLMENT/CHANGE FORM

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(1) TRANSACTION (TO BE COMPLETED BY HUMAN RESOURCES)

- ☐ ENROLLMENT
- ☐ OPEN ENROLLMENT
- ☐ ADD DEPENDENT(S)
- ☐ CANCEL COVERAGE
- ☐ AGENCY TRANSFER
- ☐ ADD DEPENDENT(S) - 6 MTH. WAITING PERIOD
- ☐ REMOVE DEPENDENT(S) - INDICATE REASON IN REMARKS SECTION
- ☐ SUPPLEMENTAL BENEFITS ONLY
- ☐ DENTAL PLAN CHANGE
- ☐ CHANGE - INDICATE REASON IN REMARKS SECTION
- ☐ REINSTATEMENT OF FULL-TIME STUDENT

(2) EMPLOYEE DATA (TO BE COMPLETED BY EMPLOYEE)

(3) MEDICAL PLAN OPTION

☐ HMO ☐ PPO ☐ CONSUMER DRIVEN HEALTH PLAN If HMO, PCP must be indicated

HEALTH CARE PLAN NAME	HEALTH CARE CENTER OR DR NAME	HEALTH CARE CENTER/DR ID#
		Are you currently a patient of this practice? ☐ Yes ☐ No

(4) DENTAL PLAN OPTION	(5) PRIMARY DENTAL OFFICE (if Concordia Plus Option selected)	United Concordia Use Only
☐ Concordia Plus Dental HMO ☐ United Concordia's Dental PPO		

(6) EMPLOYEE DEMOGRAPHIC DATA (TO BE COMPLETED BY EMPLOYEE)

SOCIAL SECURITY #

NAME (LAST PLUS SUFFIX, FIRST, MI)

TITLE ☐ Mr. ☐ Dr. ☐ Mrs. ☐ Ms.

STREET ADDRESS

COUNTY NAME

CTY CODE

SEX (M/F)

DATE OF BIRTH

CITY

STATE

ZIP

HOME TELEPHONE #

WORK TELEPHONE #

MARITAL STATUS
☐ SINGLE ☐ MARRIED ☐ DIVORCED
☐ COMMON-LAW ☐ WIDOWED

DATE OF MARRIAGE

DATE OF DIVORCE

DOES YOUR SPOUSE HAVE OTHER COMMONWEALTH COVERAGE? ☐ YES ☐ NO IF YES, SPOUSE'S SOCIAL SECURITY # ______

DO NOT LIST YOUR SPOUSE AS A DEPENDENT FOR MEDICAL AND/OR SUPPLEMENTAL BENEFITS IF THEY ARE ENROLLED SEPARATELY IN PEBTF FOR THAT COVERAGE AS AN ACTIVE OR RETIRED EMPLOYEE.

(7) COMMONWEALTH DATA (TO BE COMPLETED BY HUMAN RESOURCES)

EMPLOYEE #	POSITION #	PEBTF GROUP #	PEBTF SUB GROUP	PLAN CODE	EFFECTIVE DATE

CURRENT SERVICE DATE	DEPT. CODE	BARG. UNIT	ORG. CODE	SAP EEG	SAP ESG

(8) DEPENDENT DATA (TO BE COMPLETED BY EMPLOYEE)

ELIGIBILITY DOC. VERIFIED	SOCIAL SECURITY #	NAME (FIRST, MI, LAST)	DATE OF BIRTH (M,D,Y)	ADD OR REMOVE	HEALTH CARE CENTER/DOCTOR NAME OR ID# AND/OR DEPENDENT ADDRESS, IF DIFFERENT THAN THE EMPLOYEE
		SPOUSE		☐ ADD ☐ REMOVE	Are you currently a patient of this practice? ☐ Yes ☐ No
		☐ SON ☐ DAUGHTER ☐ OTHER (Explain Relationship)		☐ ADD ☐ REMOVE	Are you currently a patient of this practice? ☐ Yes ☐ No
		☐ SON ☐ DAUGHTER ☐ OTHER (Explain Relationship)		☐ ADD ☐ REMOVE	Are you currently a patient of this practice? ☐ Yes ☐ No
		☐ SON ☐ DAUGHTER ☐ OTHER (Explain Relationship)		☐ ADD ☐ REMOVE	Are you currently a patient of this practice? ☐ Yes ☐ No
		☐ SON ☐ DAUGHTER ☐ OTHER (Explain Relationship)		☐ ADD ☐ REMOVE	Are you currently a patient of this practice? ☐ Yes ☐ No

(9) REMARKS

AUTHORIZATION FOR APPLICATION FOR ENROLLMENT: I hereby apply for enrollment (or change) to health coverage and authorize the comptroller to adjust my payroll account or make payroll deductions, if and when applicable, with respect to my share of the cost of coverage from time to time under the benefit option I have selected. I understand that payroll deductions will be made on a before-tax basis (for federal and most state and local tax purposes) under the terms of the Commonwealth's Section 125 Plan for Health Plan Contributions. I understand this application will be submitted to, and is subject to approval by, the Pennsylvania Employees Benefit Trust Fund ("PEBTF") providing these and/or other health related benefits and will be subject to the terms of the PEBTF Plan. As condition precedent to payment of claims, and in consideration therefore, I also agree that the PEBTF shall have all legal rights of subrogation on my behalf and/or on behalf of my dependents for recovery against third parties and/or other providers legally obligated to pay such claims. Such subrogation rights shall be satisfied in full prior to the receipt by me or my dependents of any additional recovery or damages from third parties and/or other persons or entities legally obligated to pay such claims. I further agree that I will direct any attorney that I may retain to satisfy such subrogation interest in full and as a first priority prior to the distribution of any recovery to me or my dependents. Any additional documents required for release of any such information or records, or for subrogation, will be promptly signed by me and/or my dependent. I further understand that if at any time I fail to provide accurate information to the Plan or PEBTF I will be required to repay any payments made as a result of such misinformation and I will be subject to being disqualified from receiving future benefits for such period of time as the PEBTF deems appropriate. I understand that if I knowingly and with intent to defraud the Plan or PEBTF, file an application for benefits which contains materially false information or conceals information containing a material fact for the purpose of misleading, such actions by me may be deemed to be fraudulent and subject me to criminal prosecution and civil penalties. Finally, I understand that the information contained in this application for enrollment may be used by the Commonwealth of Pennsylvania and the Plan or PEBTF for such administrative and actuarial purposes as they may deem appropriate.

(10) SIGNATURE

(11) DATE

(12) HUMAN RESOURCES