



PEBTF Health Benefits Enrollment/Change Packet

Employee with Child and/or Spouse

This packet includes the following:

- Fax Cover Sheet to the HR Service Center*
- Employee Enrollment/Change Form (PEBTF-2)
- Eligibility Documentation Verification Form (PEBTF-33)

For Employees Hired On or After 8/1/2003

- Declaration of Spouse Health Coverage (PEBTF-11)
- Employer Benefit Verification form (PEBTF-36)

Instructions

1. Save a copy of this PDF file to your computer to complete the forms electronically, or print the packet to complete the forms by hand.
2. Read each form's instructions carefully.
3. On the Enrollment/Change Form (PEBTF-2), Sections 3-5, you **must** enter the effective date to indicate when you would like coverage to begin. Effective date also is required in Sections 6 and 7 as applicable.
 - a. If you are submitting this packet for open enrollment, enter an effective date of January 1 of the upcoming year.
 - b. If you are submitting this packet outside of open enrollment, you can select your effective date. However, the effective date cannot be earlier than your benefits eligibility date or more than 60 days prior to the date that your enrollment/change form (PEBTF-2) is received.
4. On the Enrollment/Change Form (PEBTF-2), Section 2, you **must** enter the "Date of Event" if applicable.

* Employees of the Office of the Attorney General, Auditor General, Liquor Control Board, Gaming Control Board and Public Utility Commission, as well as employees not under the Governor's jurisdiction, are not supported by the HR Service Center at this time. Please submit your enrollment/change packet to your local HR office.

5. Take the Eligibility Documentation Verification Form (PEBTF-33) along with the following documents to your supervisor or to your local HR office for verification and signature.

If dependent is your:

Required documents:

Spouse

- Original marriage certificate

Child

- Original birth certificate

Newborn child

- Complete this enrollment packet minus the eligibility verification within 60 days of newborn's date of birth. Do not wait until you have your child's birth certificate to enroll.
- You are required to submit the PEBTF-33 within six months of the birth date to complete your newborn's enrollment. If you do not, coverage will be terminated and you will be responsible for the cost of any claims incurred back to the date of birth.

Stepchild

- Original birth certificate and your original marriage certificate

Child by adoption/
court order

- If enrolling a child whose adoption is pending or a child by court order, a copy of the court order/adoption paperwork must be submitted along with the enrollment/change form. If this child is the only individual you are enrolling at this time, the PEBTF-33 is not required.

6. If enrolling a spouse, and you were hired on or after August 1, 2003, a completed PEBTF-11 is required.
7. If completing the packet electronically, save the completed file and print a copy.
8. Sign each form by hand.
9. Use the fax cover sheet* to submit the forms in the order listed above. **Partial packets or incomplete forms will not be accepted.**
10. Verify the fax confirmation shows a successful transmission. Retain a copy of your packet and the subsequent fax confirmation page for your records.

* Employees of the Office of the Attorney General, Auditor General, Liquor Control Board, Gaming Control Board and Public Utility Commission, as well as employees not under the Governor's jurisdiction, are not supported by the HR Service Center at this time. Please submit your enrollment/change packet to your local HR office.

INSTRUCTIONS FOR COMPLETING EMPLOYEE ENROLLMENT/CHANGE FORM (PEBTF-2)

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

Prior to selecting your medical plan, make sure that you review your Summary Plan Description (SPD). You may visit the PEBTF website, www.pebtf.org to view the SPD and to link to the medical plans. You will be able to search for network providers on each medical plan's site. Contact the PEBTF at 1.800.522.7279 with questions regarding your benefits. If you have questions about completing this form, contact the HR Service Center at 1.866.377.2672 or your local HR office if your agency is not supported by the HR Service Center.

**TO COMPLETE THIS FORM ONLINE, YOU MUST HAVE ADOBE 4.0 OR HIGHER
COMPLETE EACH SECTION OF THE FORM UTILIZING THE "HAND TOOL" IN THE ADOBE ACROBAT
PROGRAM**

**After you have completed the form, submit the form to the HR Service Center or
your local HR office if your agency is not supported by the HR Service Center.**

Refer to Corresponding Sections on the Enrollment Form

- Section 1:** This section is to be completed by the employee. **EMPLOYEE DATA.** Complete all information.
- Section 2:** This section is to be completed by the employee. **ENROLLMENT INFORMATION.** Indicate the reason(s) for completing the enrollment form. If it is due to a qualifying life event, please list the date of the event as well as the effective date for coverage. Qualifying life events include but are not limited to: Marriage, birth or adoption, divorce, dependent gains or loses coverage under another health plan, employee relocates and is no longer eligible for his/her current plan, cost of coverage of a plan option changes significantly or plan option is no longer available.
- Section 3:** This section is to be completed by the employee. **MEDICAL BENEFITS.** Please indicate the medical plan option. The Bronze Plan is only for non-permanent and permanent part-time employees working an average of 30 hours per week who have been notified that they are eligible for this plan. If you are choosing the PEBTF Custom HMO, you **must** complete the primary care physician information under Health Care Center and include the Provider ID#. The Provider ID # can be found on the health plan's website under the provider search. If you don't have the ID #, please make sure you include the doctor's full name. Also, if you are not currently a patient of the medical practice, call the doctor's office to confirm they are accepting new patients.
- Section 4:** This section is to be completed by the employee. **PRESCRIPTION DRUG BENEFITS** (available as a separate plan). If you are a full-time employee and enroll in medical benefits, you will be automatically enrolled in prescription drug benefits after your first 90-days of employment. If you do not want to be enrolled in prescription drug benefits, indicate by checking "Decline." The Bronze plan includes prescription drug benefits that are separate from this regular plan and are subject to the plan deductible.

Section 5: This section is to be completed by the employee. **SUPPLEMENTAL BENEFITS** If you are a full-time employee and enroll in medical benefits, you will be automatically enrolled in Supplemental Benefits (dental, vision and hearing aid coverage) after your 90-days of employment. If you do not want to be enrolled in Supplemental Benefits, indicate by checking "Decline." The Bronze plan does not include these benefits.

Section 6: This section is to be completed by the employee. **SPOUSE DATA** Please list the spouse that will be enrolled in PEBTF benefits and answer all questions. Your spouse can be enrolled in any of the plans in which you are enrolled. You will need to present documentation verifying the eligibility status for the spouse included on this enrollment form. It is your responsibility to advise the HR Service Center or your local HR office if your agency is not supported by the HR Service Center of any changes to your spouse's eligibility status.

Spouse Coverage (regardless of employee's hire date): If your spouse is enrolled in a plan with a Health Savings Account (HSA), he or she may not be eligible to enroll in other coverage as secondary. Your spouse should speak with his or her employer prior to enrolling in a PEBTF plan for secondary coverage.

Employees hired on or after August 1, 2003: Your spouse must enroll in his or her employer's health benefits for primary coverage even if there is a required employee contribution or a monetary incentive to decline. Your spouse's coverage under the PEBTF is secondary to his or her employer's coverage.

Employees hired prior to August 1, 2003: Your spouse may enroll in PEBTF benefits as primary coverage if his or her employer's coverage is offered at a cost or if there is a monetary incentive to decline. If your spouse keeps his or her employer's coverage, PEBTF coverage under the PEBTF is secondary.

Section 7: This section is to be completed by the employee. **DEPENDENT DATA:** Only eligible children to age 26 should be included on this enrollment form. Your dependent(s) can be enrolled in any of the plans in which you are enrolled. You will need to present documentation verifying the eligibility status for the dependent(s) included on this enrollment form. It is your responsibility to advise the HR Service Center or your local HR office if your agency is not supported by the HR Service Center of any changes to your dependents' eligibility status.

NOTE: Should dependent eligibility or any other information on this enrollment form change at any time, eligibility for coverage may be reconsidered by the PEBTF.

Section 8: This section is to be completed by the employee. **Please SIGN AND DATE the form.** Submit the form to the HR Service Center or your local HR office if your agency is not supported by the HR Service Center. Form must be signed in ink. Electronic signatures are not acceptable.

Section 9: Do not write in this section. This section is for HR Service Center or HR Office use only.

Section 10: Do not write in this section. This section is for HR Service Center or HR Office use only.



EMPLOYEE ENROLLMENT/CHANGE FORM

Important: Changes made on this form will affect your medical, prescription drug, and supplemental benefits.

SECTION 1: EMPLOYEE DATA

Social Security #	Title <input type="checkbox"/> Mr. <input type="checkbox"/> Dr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Name (Last Plus Suffix, First, MI)	Employee #
Street Address			Local Municipality (if address change)
City/State/Zip			County Name
Mailing Address (if different than address listed above)		City/State/Zip	
Home Phone #	Cell Phone #	Work Phone #	Date of Birth (mm/dd/yyyy) Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Relationship Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Common Law			Date of Marriage (mm/dd/yyyy)
Answer both of the following questions: Are you covered by another medical plan? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No			

SECTION 2: ENROLLMENT INFORMATION

a) Action Requested (select all that apply):

New Enrollment Add/Remove Dependent(s) Plan Change Dependent Data Change/Correction

Open Enrollment (effective January 1 of next calendar year)

b) Event (select all that apply):

Marriage Birth/adoption of child Divorce Death Termination of Benefits

Address Change Other (Reason): _____

c) Date of Event:
(if applicable) (mm/dd/yyyy)

SECTION 3: MEDICAL BENEFITS (Select one)

Full-Time Employees: Additional costs may apply if selecting the CHOICE PPO.
Part-Time Employees: Additional costs will apply for any plan selection.

CHOICE PPO BASIC PPO PEBTF CUSTOM HMO

Decline Bronze (only available if you have been notified that you are eligible) **Effective Date (mm/dd/yyyy):** _____

Medical Plan Name	Health Care Center or Dr. Name (required for HMO)	Health Care Ctr/Provider ID #
Are you currently a patient of this practice? <input type="checkbox"/> Yes <input type="checkbox"/> No		

SECTION 4: PRESCRIPTION DRUG BENEFITS

If enrolling in prescription drug plan only, also complete the PEBTF-41 form

Full-Time Employees: Additional costs will apply for the first 90 days of employment. Part-Time Employees: Additional costs will apply.

Decline Enroll **Effective Date (mm/dd/yyyy):** _____

SECTION 5: SUPPLEMENTAL BENEFITS (Includes dental, vision and hearing aid coverage)

Supplemental Benefits will begin no earlier than after 90 days of employment.
Part-Time Employees: Additional costs will apply.

Decline Enroll **Effective Date (mm/dd/yyyy):** _____

SECTION 6: SPOUSE DATA

Complete this section if adding or removing a spouse. If adding a new spouse, you must present your original marriage certificate to your local HR office or your supervisor.

HR initial Eligibility Doc Verified	Name (Last, First, MI)	Spouse SSN	Gender	Date of Birth (mm/dd/yyyy)
			<input type="checkbox"/> Female <input type="checkbox"/> Male	

List address and telephone number if different than the employee:

- Does your spouse have Medicare?
 Yes No
- Is your spouse covered by another medical plan?
 Yes No
- My spouse is currently (Select One):
 A Commonwealth of Pennsylvania employee or retiree
 Employed, either Full-Time or Part-Time, or Retired (answer questions 4, 5 and 6)
 Not Employed or Self-Employed (do not answer remaining questions)
- Is your spouse eligible for health coverage through his or her employer or former employer?
 Yes
 No
- Is your spouse enrolled in his/her employer's health insurance or enrolled in a retiree health insurance plan?
 Yes A copy of your spouse's medical ID card must be submitted with this form.
 - Is the plan offered at a cost? Yes No
 - Is there a monetary incentive to decline coverage? Yes No No
 Not applicable
- Does your spouse have an HSA (Health Savings Account)? Yes No Not applicable
 (There may be tax implications if he or she enrolls in a PEBTF plan as secondary.)

	Add	Remove	Effective date (mm/dd/yyyy)	
Medical plan	<input type="checkbox"/>	<input type="checkbox"/>		Health Care Center/Doctor Name (required for HMO) Health Care Ctr/Provider ID #
				Currently a patient of this practice? <input type="checkbox"/> Yes <input type="checkbox"/> No
Prescription drug plan <i>If enrolling in prescription drug plan only, also complete the PEBTF-41 form</i>	<input type="checkbox"/>	<input type="checkbox"/>		Remarks:
Supplemental benefits (dental/vision/hearing aid plans)	<input type="checkbox"/>	<input type="checkbox"/>		
Personal data change/correction: identify in Remarks				

(Form continues next page)

SECTION 7: DEPENDENT DATA *(Complete second form if you have additional dependents)*

Complete this section if adding or removing dependents. If adding a new dependent, you must present additional documentation such as a birth certificate to your local HR office or your supervisor.

Eligibility Verified by HR	Name (Last, First, MI)	Dependent SSN	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth (mm/dd/yyyy)
<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other, explain relationship:				
List address and telephone number if different than the employee:				
a) Does your dependent have Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No b) Is your dependent covered by another plan? <input type="checkbox"/> Yes <input type="checkbox"/> No				

	Add	Remove	Effective date (mm/dd/yyyy)	
Medical plan	<input type="checkbox"/>	<input type="checkbox"/>		Health Care Center/Doctor Name (required for HMO) Health Care Ctr/Provider ID # <hr/> Currently a patient of this practice? <input type="checkbox"/> Yes <input type="checkbox"/> No
Prescription drug plan <i>If enrolling in prescription drug plan only, also complete the PEBTF-41 form</i>	<input type="checkbox"/>	<input type="checkbox"/>		Remarks:
Supplemental benefits (dental/vision/hearing aid plans)	<input type="checkbox"/>	<input type="checkbox"/>		
Personal data change/correction: identify in Remarks				

Eligibility Verified by HR	Name (Last, First, MI)	Dependent SSN	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth (mm/dd/yyyy)
<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other, explain relationship:				
List address and telephone number if different than the employee:				
a) Does your dependent have Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No b) Is your dependent covered by another plan? <input type="checkbox"/> Yes <input type="checkbox"/> No				

	Add	Remove	Effective date (mm/dd/yyyy)	
Medical plan	<input type="checkbox"/>	<input type="checkbox"/>		Health Care Center/Doctor Name (required for HMO) Health Care Ctr/Provider ID # <hr/> Currently a patient of this practice? <input type="checkbox"/> Yes <input type="checkbox"/> No
Prescription drug plan <i>If enrolling in prescription drug plan only, also complete the PEBTF-41 form</i>	<input type="checkbox"/>	<input type="checkbox"/>		Remarks:
Supplemental benefits (dental/vision/hearing aid plans)	<input type="checkbox"/>	<input type="checkbox"/>		
Personal data change/correction: identify in Remarks				

TERMS AND CONDITIONS

1. I hereby apply to enroll (or change) medical and/or prescription drug, and/or supplemental benefits in the Pennsylvania Employees Benefit Trust Fund ("Plan") for me and/or my dependents (as defined in the Plan) and declare that the foregoing information is true and correct to the best of my knowledge and belief. I understand that eligibility for coverage and payment of benefits under the Plan in all instances is subject to the terms of the Plan and that any false or misleading information that I provide to the Plan regarding the status of any dependent and any other medical or supplemental coverage that may be applicable may result in the suspension or termination of coverage under the Plan and may require the repayment to the Plan of any benefits paid under the Plan, in addition to the imposition of criminal and civil penalties. I understand that I must inform the Plan of any changes in the employment status of any dependents which may affect their eligibility under the Plan and that my failure to do so may result in the loss of coverage, repayment of any amounts paid on their behalf, in addition to the imposition of criminal and civil penalties.

2. I authorize any payroll deduction relating to my share of the cost of such coverage and understand that such deductions will be made on a pre-tax basis to the extent permitted by law.

3. I further understand that the Plan has the right to subrogate, on my behalf and on behalf of any dependent, against any third parties or others obligated to pay any claims which the Plan has paid or may pay. I agree that I will direct any attorney that I may retain to satisfy such subrogation interest in full prior to receipt by me or my dependents of any recovery to which I and/or my dependents may be entitled and to otherwise fully cooperate with the Plan regarding all subrogation matters.

4. I further understand that the Plan includes a coordination of benefits provision and agree to fully cooperate with the Plan regarding all coordination of benefit matters. I acknowledge that in the event the Plan concludes that I have provided any false or misleading information, or failed to appropriately cooperate with the Plan, regarding any subrogation or coordination of benefit matters, the Plan may suspend or terminate my coverage or my dependents' coverage under the Plan and take such other action as it deems appropriate.

SECTION 8 : EMPLOYEE AGREEMENT AND SIGNATURE

"I certify that the information entered on this form is true and complete and that I agree to all of the Terms and Conditions listed above and in the PEBTF Summary Plan Description and Plan Document."

Employee Name

Employee Signature

Date

Form must be signed in ink. Electronic signatures will not be accepted.

SECTION 9: COMMONWEALTH DATA (to be completed by HR Service Center or HR Office)

Position #	PEBTF Group #	PEBTF Sub Group	Plan Code	County Code	
Current Service Date	Dept. Code	Barg. Unit	Org Code	SAP EEG	SAP ESG

Is employee ACA eligible for the Bronze Plan (works average of 30 hours per week)? Yes No

SECTION 10: HR REMARKS

HR Service Center or HR Office Signature	Date Enrollment Form Received	Date Enrollment Form Processed

**Instructions for Completing Section 2
Eligibility Documentation Verification Form
For PEBTF Benefits Enrollment/Change (PEBTF-33)**

The local HR office or employee's supervisor (verifier) must view original documents for employees requesting to add dependents to their health insurance benefits. The following documents have been approved by the Pennsylvania Employees Benefit Trust Fund (PEBTF) as verification of a dependent's eligibility for coverage.

How to verify (completion of Section 2):

- Review each document to verify that an original has been presented (no photocopies).
- Clearly and legibly print all applicable fields. Be sure to identify Dependent Type.
- Ensure the accuracy of information as printed on the PEBTF-33 matches the original document.
- List the date of marriage and/or dates of birth as given in the original documents. Under no circumstance should the date be altered.
- Check the box in each row as you complete the verification for it.

(1) Spouse

- a. Employee must present the original court-issued marriage certificate (cannot be a photocopy).
- b. If the employee did not get married in the US and the marriage certificate is not able to be read (due to language it is written in) or verified, refer the employee to the HR Service Center for further instructions.

(2) Child

- a. Employee must present the child's original or new birth certificate (cannot be a photocopy). Employee's name must appear on birth certificate.
- b. If enrolling a child whose adoption is pending or a child by court order, a copy of the adoption paperwork/court order must be submitted along with the Employee Enrollment/Change Form (PEBTF-2). If this child is the only dependent you are enrolling at this time, the PEBTF-33 is not required until you have the new birth certificate.

(3) Stepchild

- a. Employee must present an original marriage certificate.
- b. Employee must present the child's original birth certificate indicating that the spouse is the parent of the child.

If you have any questions regarding the completion of this document, please call the HR Service Center at 1.866.377.2672.

**ELIGIBILITY DOCUMENTATION VERIFICATION FORM
For PEBTF Benefits Enrollment/Change**

This form must be completed by an employee's supervisor or local HR representative.

Section 1 – To Be Completed By HR Office or Supervisor

I, _____, am submitting this form as verification that I

 Verifier Name (Print)
 have viewed the original required documentation listed below as proof of eligibility for PEBTF health
 benefits for:

 Employee Name (print)

 Employee Number

Please complete the following chart for each dependent that is being added to coverage.

Section 2 – To Be Completed By HR Office or Supervisor

Dependent Type	Dependent's Name (Last, First, MI)	Document (Original documents must be viewed)	Date of Marriage	Spouse Date of Birth	Check after Verifying Data Accuracy
Spouse		Marriage Certificate		N/A	<input type="checkbox"/>
Spouse		Birth Certificate (Required only to correct DOB)	N/A		<input type="checkbox"/>
Dependent Type - Son - Daughter - Other (explain)	Dependent's Name (Last, First, MI)	Document (Original documents must be viewed)	Date of Birth	Name of Mother/ Father on Birth Certificate	Check after Verifying Data Accuracy
		Birth Certificate*		Mother	align="center"> <input type="checkbox"/>
				Father	
		Birth Certificate*		Mother	align="center"> <input type="checkbox"/>
				Father	
		Birth Certificate*		Mother	align="center"> <input type="checkbox"/>
				Father	

*Verify that the name of the employee or spouse appears on the dependent's birth certificate.

Section 3 – To Be Completed by HR Office or Supervisor and Employee

I certify that this information is correct to the best of my knowledge. By signing this Form, I am certifying that the original documents indicated above have been presented and verified.

 Employee's Signature

 Date

 Verifier's Signature

 Date

 Verifier's Phone Number

 Verifier's Name (print)

 Title/Position

Employees must submit this form to the HR Service Center along with the PEBTF-2 and any other required documentation to:

Fax: 717.425.7190

US Mail: HR Service Center
 PO Box 824
 Harrisburg, PA 17108-0824

**PENNSYLVANIA EMPLOYEES BENEFIT TRUST FUND
DECLARATION OF SPOUSE HEALTH COVERAGE
For Employees Hired on or After 8/1/2003**

If your spouse is eligible for health benefits through his/her employer (or former employer), he or she must enroll in their employer's benefits. This requirement applies regardless of the cost of such coverage to your spouse. Your spouse can be enrolled in the PEBTF for secondary coverage only. Any claims must be submitted to your spouse's employer-sponsored health plan before they can be submitted for consideration of payment through the PEBTF health plans. The following information is required to confirm your spouse's eligibility and enrollment in their employer's health plan.

Employee and Spouse Information

Employee Name: _____ Employee Number: _____ Employee Date of Birth: _____

Spouse Name:
<p>1. My spouse is currently (Select One):</p> <p><input type="checkbox"/> Employed, either Full-Time or Part-Time, or Retired (proceed to Question #2)</p> <p><input type="checkbox"/> Not Employed or Self-Employed (no further action required) – Sign, date and submit the form (proceed to #5)</p>
<p>2. Is your spouse a commonwealth employee or a retiree eligible for PEBTF or majority-state paid Retired Employees Health Program (REHP) coverage?</p> <p><input type="checkbox"/> If yes, sign, date and submit form. Proceed to #5.</p> <p><input type="checkbox"/> If no, proceed to Question #3.</p>
<p>3. Is your spouse eligible for health coverage through his/her employer or former employer?</p> <p><input type="checkbox"/> If yes, proceed to Question #4.</p> <p><input type="checkbox"/> If no, your spouse's employer must complete an Employer Benefit Verification Form (PEBTF- 36). Proceed to #5.</p>
<p>4. Is your spouse enrolled in his/her employer's health insurance or enrolled in a retiree health insurance plan?</p> <p><input type="checkbox"/> If yes, sign, date and submit the form and provide copies of your spouse's medical insurance card. Proceed to #5.</p> <p><input type="checkbox"/> If no, sign, date and submit form. <i>Your spouse is not eligible for PEBTF coverage until he/she enrolls in his/her employer's health insurance.</i> Proceed to #5.</p>
<p>Please note: If your spouse is enrolled in a Health Savings Account and you enroll them in the PEBTF plan as secondary coverage, your spouse may incur financial penalties. Please verify with your spouse's plan that your spouse will not be subject to financial penalties before enrolling him/her in the PEBTF.</p>

5. Signature: I declare that the foregoing information is true and correct to the best of my knowledge, information and belief. I understand that the PEBTF reserves the right to suspend or terminate my PEBTF group health plan coverage if it concludes I have provided false or misleading information in this Declaration. I understand that if my spouse is eligible to enroll under his/her employer's group health plan and does not, he/she is not eligible to be covered as a dependent in the PEBTF Plan. For medical expenses incurred by my spouse, the PEBTF will pay only secondary benefits and will consider claims for payment only after they have been submitted to my spouse's employer's plan. If my spouse becomes employed or changes employment or his/her eligibility for health coverage changes, I agree to notify the HR Service Center (or my local HR Office for agencies not supported by the HR Service Center) and complete an updated Declaration of Spouse Health Coverage (PEBTF-11). I understand that the PEBTF may cancel my benefits (and my family's benefits) and I may be held responsible for costs in the event that it has been determined that the information provided was false or that my spouse was not eligible for benefits.

Employee Signature

Date

PEBTF

Employer Benefit Verification Form For Employees Hired on or After 8/1/2003

****Form must be submitted within 30 days of signature date****

The Pennsylvania Employees Benefit Trust Fund (PEBTF) provides health benefits to Commonwealth of Pennsylvania employees and retirees. The below-referenced member is enrolled in PEBTF health benefits as a spouse of a commonwealth employee. For employees hired on or after 8/1/03, PEBTF eligibility rules require that the spouse **must** take his or her own employer's health benefit coverage even if he or she has to pay for the coverage or if the employer offers an incentive to decline the coverage. The spouse must have primary coverage through his or her employer's coverage and may remain on PEBTF benefits for secondary coverage.

To be completed by the PEBTF employee member	
Please print information below	
1. Commonwealth employee's name:	
2. Commonwealth employee number:	
3. Commonwealth employee's date of birth (mm/dd/yyyy):	
4. Spouse's name:	
5. Spouse's date of birth (mm/dd/yyyy):	
6. My spouse is employed:	<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time
7. My spouse is retired:	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Employee's signature:	

To be completed by an authorized representative of the spouse's employer:	
9. Company name:	
10. Is the spouse eligible for health insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No (sign and date form)
11. If yes, please indicate the date that the spouse became eligible for benefits.	Initial Eligibility Date (mm/dd/yyyy): _____
12. Is the spouse currently enrolled in your company's health insurance?	<input type="checkbox"/> Yes Effective Date of Enrollment (mm/dd/yyyy): _____ <input type="checkbox"/> No Last Date of Coverage (mm/dd/yyyy): _____

_____	_____
Employer Representative (print name)	Title
_____	_____
Employer Representative Signature	Date

	Telephone Number

PEBTF, 150 S. 43rd Street, Harrisburg, PA 17111

PEBTF-36
Rev 11-2019