



PSERS HEALTH OPTIONS PROGRAM APPLICATION

Enrollment/Change/Termination Request

HOP Administration Unit

P.O. Box 1764 Lancaster, PA 17608-1764

Phone: 1-800-773-7725 Fax: 1-866-336-7124

Please Do Not Write In This Space

Plan #: _____ Effective Date: _____ Premium: _____

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REASON FOR SUBMITTING FORM Check all that apply.

Qualifying Event Adding Spouse Option Selection Period Terminate HOP Coverage Effective _____ (date)

RETIREE INFORMATION This section must identify the PSERS retiree.

If the retiree is **NOT** to be covered, check here If the retiree is currently enrolled, check here

Marital Status Married Single Widowed Divorced Separated

Retiree's Name _____

Gender Male Female **Social Security No.** _____

Birth Date ____/____/____ **Retirement Date** ____/____/____ **Phone** (____) _____

Address _____

E-mail Address _____

Medicare Information _____

Desired Effective Date* _____

Note: You must be enrolled in BOTH Medicare Part A and Part B to enroll in the HOP Medical Plan. However, you need only be enrolled in EITHER Medicare Part A or Part B to enroll in one of the Medicare Rx Options on a standalone basis.

DEPENDENT INFORMATION

If additional dependents are to be covered, provide the requested information on an additional application.

Relationship to PSERS Retiree Spouse Child

Name _____

Gender Male Female **Social Security No.** _____

Birth Date ____/____/____ **Phone** (____) _____

Address _____

Medicare Information _____

Desired Effective Date* _____

OPTION SELECTION

- HOP Medical Plan only (no prescription coverage)
- HOP Medical Plan with Basic Medicare Rx Option
- HOP Medical Plan with Enhanced Medicare Rx Option
- HOP Basic Medicare Rx Option only (no medical coverage)
- HOP Enhanced Medicare Rx Option only (no medical coverage)
- HOP **Pre-65** Medical Plan with prescription drug coverage
- HOP **Pre-65** Medical Plan without prescription drug coverage

Will You Have Other Medical Coverage When Your HOP Coverage Begins? _____ No _____ Yes

If Yes, indicate name of **other** insurance company _____

Will You Have Other Prescription Drug Coverage When Your HOP Coverage Begins? _____ No _____ Yes

If Yes, indicate name of **other** insurance company _____

Insurance company name _____

Pennsylvania PACE, Pace Net or VA coverage

Previously enrolled in Medicare Rx Plan: _____ # of months

Dates of coverage _____ to _____

You may belong to an employer group or trust fund health plan whose drug coverage is as good or better than standard Medicare Prescription Coverage (Part D). It is important that you consider your decision to enroll in our plan carefully.

To finalize your request for enrollment in our plan, we need you to confirm that you want to be enrolled in this group sponsored plan by signing below.

STATEMENT OF AUTHORIZATION

By signing this form I acknowledge reading and agreeing to the terms and conditions on the **BACK OF THIS FORM**. I understand that my signature certifies that I have read and/or understand the contents of this application.

Retiree's Signature _____ **Date** _____ **Spouse's Signature** _____ **Date** _____

Application must be completed prior to, but no more than 90 days before, the effective date. Attach a copy of each enrollee's Medicare card.

* Include 1st month premium payment if submitting this application less than six weeks prior to the desired effective date.



STATEMENT OF APPLICATION

1. I understand this application is subject to approval by the Health Options Program, a voluntary health benefits plan sponsored by the Pennsylvania Public School Employees' Retirement System, and any coverage provided will be subject to the terms of the applicable description of benefits and standard health insurance procedures and practices. Any person or organization having provided or who may provide health care services to me or any person named on this application either prior to or during the period of coverage is authorized to furnish the PSERS Health Option Program and any third party payor any information or records relating to these services.
2. I understand that premiums will be deducted from my monthly benefit from PSERS unless the amount of the monthly benefit is insufficient to cover the premium, at which time I will be billed directly.
3. I understand that my election of a coverage Option is for the following calendar year or the remainder of the current calendar year and cannot be changed during the year unless I have a "Qualifying Event" as defined in the communication materials.
4. I understand that my signature on this application certifies that I have read and/or understand the contents of this application.
5. If Medicare eligible, I understand that I must also maintain my Part B benefits under the Medicare program.
6. I verify that the information given in this application is true and correct and understand that false statements made herein or fraudulent claims made hereunder are subject to penalties to 18 PA C.S.A. §4117 relating to health insurance fraud.
7. I understand that I will not be eligible for prescription drug coverage through the PSERS Health Options Program if I elect Medicare Prescription Drug Coverage (Part D) from another provider.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

RELEASE OF INFORMATION:

By joining this Medicare prescription drug plan, I acknowledge that HOP will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by HOP or by Medicare.

BY COMPLETING THIS ENROLLMENT APPLICATION, I AGREE TO THE FOLLOWING:

HOP is a Medicare drug plan and is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare coverage. It is my responsibility to inform HOP of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare prescription drug plan at a time. Enrollment in this plan is generally for the entire year. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to HOP or by calling 1-800-Medicare. TTY users should call 1-877-486-2048.

Once I am a member of HOP, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from HOP when I receive it to know which rules I must follow in order to receive coverage with this Medicare drug plan.