

PENNSYLVANIA EMPLOYEES BENEFIT TRUST FUND
DECLARATION OF SPOUSE HEALTH COVERAGE
For Retirees, who as Active Employees, Were Hired on or After 8/1/2003

If your spouse is eligible for health benefits through their employer (or former employer), they must enroll in their employer's benefits (either as an employee or retiree). This requirement applies regardless of the cost of such coverage to your spouse. Your spouse can be enrolled in the REHP non-Medicare health benefits 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 REHP health plans. The following information is required to confirm your spouse's eligibility and enrollment in their employer's health plan.

Retiree and Spouse Information

Retiree Name: _____ Last 4 Digits of Social Security Number: _____

Retiree Date of Birth: _____

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

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 REHP 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 their employer's group health plan and does not, they are not eligible to be covered as a dependent in the REHP Plan. For medical expenses incurred by my spouse, the REHP 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 their eligibility for health coverage changes, I agree to notify the State Employees' Retirement System (SERS) and complete an updated Declaration of Spouse Health Coverage (PEBTF-11_Retiree). I understand that the REHP 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.

Retiree Signature

Date