

2025 PEBTF Open Enrollment Form for REHP Members

This form should be completed only if you are **not Medicare eligible** and you want to make a plan change for 2026. All other changes must be reported to your local Retirement Counseling Office. To verify whether your current physician participates with the Custom HMO in your area 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.**

Please complete all sections.

Social Security Number	Employee Name (First, MI, Last)	Date of Birth
Street Address	City	State Zip
County of Residence	Home Telephone Number	Open Enrollment Effective Date 1/1/2026

Indicate the medical plan option below. Additional costs may apply if selecting the AETNA CHOICE PPO (only for retirees hired on or after 8/1/03).

☐ Choice PPO Option - Aetna

☐ Basic PPO Option - Aetna

☐ Custom HMO Option - Aetna

If enrolling in the Custom HMO Option: List Primary Physician Name or Number for each enrolled dependent.
(refer to the Custom HMO's online provider directory on www.pebtf.org for this information)

Physician Name or Physician ID #

Name:

Name:

Name:

Name:

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 by fax (717) 307-3371, email to eligfax@pebtf.org or postmarked by October 31, 2025.
PEBTF, 150 South 43rd Street, Suite 1, Harrisburg, PA 17111-5700 (717) 561-4750 or 1-800-522-7279