# State Police Annuitant 2025 Open Enrollment Form

| Member Name | Social Security # | |
|---|---|---|
| Address | City | |
| County | State | Zip Code |
| Date of Birth | Home Telephone | Work Telephone |

Current Medical Plan

[ ] Traditional Classic Blue

[ ] PPOBlue

New Medical Plan

[ ] Traditional Classic Blue

[ ] PPOBlue

**Please complete all dependent information below.**

Failure to list all dependents will result in the dependents being removed from your health benefits.

| Dependent Name<br>First, MI, Last | Social Security # | Date of Birth |
|---|---|---|
| Spouse | | |
| Son [ ] Daughter [ ] | | |
| Son [ ] Daughter [ ] | | |
| Son [ ] Daughter [ ] | | |
| Marital Status<br>SINGLE [ ] MARRIED [ ] OTHER [ ] | | |

Authorization for application for Open Enrollment Change -- I request and apply for enrollment for health insurance coverage. I understand this application will be submitted and is subject to approval by the Plan or the Commonwealth providing this health benefit coverage and will be subject to the terms of the agreement between the Commonwealth and such Plan. Any person or organization that has provided health related services to me or any of my dependents named on this application, either prior to or during, agree that the Plan or the Commonwealth 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 obligated 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 _____

This form should be completed and returned to:

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

Please complete the form if you want to make a plan change effective January 1, 2026.

PEBTF **must** receive the completed form by **Friday, November 7, 2025.**