

**THE PENNSYLVANIA STATE UNIVERSITY  
BENEFITS ENROLLMENT FORM  
POST DOCS**

Please return this form if enrolling or declining benefits to Penn State University, Employee Benefits Division,  
114 Rider I Building, University Park, PA 16802 within 31 days of hire.

If medical, dental, and/or vision coverage is desired more than 31 days after the date of hire, coverage can  
only be added during the Open Enrollment period in the fall unless a qualifying event has occurred.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

PSU I.D. Number \_\_\_\_\_ Campus Location: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Sex: Male \_\_\_\_\_ Female \_\_\_\_\_

**My choice for Highmark PPOBlue medical coverage is:**

- Self Only    
  Self & Spouse/  
Domestic Partner    
  Self and Child(ren)    
  Self, Spouse/Domestic Partner  
and Child(ren)    
  NO COVERAGE

**My choice for dental coverage is:**

- Self Only    
  Self & Spouse/  
Domestic Partner    
  Self and Child(ren)    
  Self, Spouse/Domestic Partner  
and Child(ren)    
  NO COVERAGE

**My choice for vision coverage is:**

- Self Only    
  Self & Spouse/  
Domestic Partner    
  Self and Child(ren)    
  Self, Spouse/Domestic Partner  
and Child(ren)    
  NO COVERAGE

**My choice for life insurance is:**

- NO COVERAGE  
 An amount of life insurance equal to one times annual stipend (rounded to the nearest \$1,000), to a maximum of \$50,000.

**Ages:**                      **Under 25**    **25-29**    **30-34**    **35-39**    **40-44**    **45-49**    **50-54**    **55-59**    **60-64**    **65-69**    **70 & over**

**Monthly Contributions**    **.05**    **.06**    **.08**    **.09**    **.12**    **.20**    **.31**    **.51**    **.80**    **1.43**    **2.55**  
**(per \$1000 of coverage)**

List the name(s) of any person(s) you wish to designate as beneficiary(ies). If more than one person is named, the death benefit, unless otherwise provided herein, will be paid in equal shares to the designated beneficiaries who survive. IF A PRIMARY AND SECONDARY ARRANGEMENT IS DESIRED, YOU SHOULD SPECIFICALLY IDENTIFY THEM. If in the event, the designated beneficiary(ies) is deceased, payment will be made in accordance with the policy. The beneficiary designation may be changed at any time.

Name of Beneficiary(ies)	Specify Primary/Secondary	Relationship	Address of Beneficiary(ies)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Please list all dependents you are covering under your insurance.**

<b>Full Name (Last, First, Mi)</b>	<b>Sex</b>	<b>Relation</b>	<b>Date of Birth</b>	<b>Social Security Number</b>	<b>Please indicate coverage for medical, dental, and/or vision for yourself and each dependent.</b>
	M / F	<b>Self</b>			<b>Medical</b> Y or N <b>Dental</b> Y or N <b>Vision</b> Y or N
	M / F	<b>Spouse/ Domestic Partner</b>			<b>Medical</b> Y or N <b>Dental</b> Y or N <b>Vision</b> Y or N
	M / F	<b>Child</b>			<b>Medical</b> Y or N <b>Dental</b> Y or N <b>Vision</b> Y or N
	M / F	<b>Child</b>			<b>Medical</b> Y or N <b>Dental</b> Y or N <b>Vision</b> Y or N
	M / F	<b>Child</b>			<b>Medical</b> Y or N <b>Dental</b> Y or N <b>Vision</b> Y or N
	M / F	<b>Child</b>			<b>Medical</b> Y or N <b>Dental</b> Y or N <b>Vision</b> Y or N

**V. Certification/Signature**

I hereby accept the forms of insurance and coverage contracted for by the University in the amounts for which I am or may be eligible to elect under Highmark PPOBlue, Dental, Vision, and Life Insurance, and authorize the University to make the necessary deductions from my earnings to cover my contributions for the coverage. I authorize any physician, hospital, other medical provider, and persons or organizations involved in utilization review, peer review, and other plan administrative duties to disclose to the health plan administrator any medical information relating to the individuals specified on this application.

\_\_\_\_\_  
**SIGNATURE**

\_\_\_\_\_  
**DATE**

**Please return your enrollment form to:** Penn State University  
Employee Benefits Division  
114 Rider I Building  
University Park, PA 16802

**FOR OFFICE USE ONLY**

Branch Code \_\_\_\_\_ Effective Date \_\_\_\_\_ EBD Initials \_\_\_\_\_ Date \_\_\_\_\_