RETIRED EMPLOYEE PLAN CHANGE FORM

SELECT (CHECK) ONLY ONE

☐	**SEHIP Medical *** To add dental attach Form IB21 To add vision attach Form IB20 To add cancer attach Form IB23	☐	**Supplemental Coverage Plan** To add dental attach Form IB21 To add vision attach Form IB20 To add cancer attach Form IB23	☐	**Blue Advantage** To add dental attach Form IB21 To add vision attach Form IB20 To add cancer attach Form IB23	☐	**Vision & Dental Coverage Only** Attach Forms IB20 and IB21
				☐	**Southland Optional Policies** Vision / Dental / Cancer / Hospital Indemnity	☐	**Vision, Dental & Cancer Only** Attach Forms IB20, IB21 & IB23
☐	**Southland – Dental Only**	☐	**Southland – Vision Only**	☐	**Southland – Vision & Cancer Only** Attach Forms IB20 and IB23	☐	**Decline All Coverage**
☐	**Southland –Cancer Only**	☐	**Dental & Cancer Only** Attach Forms IB21 and IB23	☐	**Blue Cross – Dental Only**		

SUBSCRIBER INFORMATION

Name (First, Middle Initial, Last)	Sex:	Effective Date of Coverage
Social Security Number:	Date of Birth:	
Street Address:		
City:	State:	ZIP Code:
Home Telephone Number:	Work Telephone Number:	E-mail Address:

First Name Middle Initial Last Name	Relationship to Employee (Documentation of relationship to employee is required for all plans except Supplemental)		Date of Birth	Social Security Number and Medicare Number (if applicable)
	☐ **Male Spouse***	☐ **Female Spouse***		
	☐ **Son** ☐ **Stepson**	☐ **Daughter** ☐ **Stepdaughter**		
	☐ **Son** ☐ **Stepson**	☐ **Daughter** ☐ **Stepdaughter**		
	☐ **Grandson** ☐ **Nephew**	☐ **Granddaughter** ☐ **Niece**		

***IMPORTANT:** To be eligible for the non-tobacco and/or wellness discount, you must submit a completed Non-Tobacco User Discount Application and meet the requirements of the Wellness Program. When adding a spouse to SEHIP coverage, a spousal surcharge of $50 per month will be applied. To receive a discount you must submit a completed Spousal Surcharge Waiver Application (IB28). Forms are available at www.alseib.org

ADDITIONAL GROUP HEALTH INSURANCE COVERAGE

☐ **Medicare Part A** ☐ **Medicare Part B** ☐ **Other (specify)** _____

PRIMARY GROUP HEALTH INSURANCE COVERAGE INFORMATION
(Must be completed if choosing supplemental coverage or optional policies.)

Does the ***primary coverage*** have a spousal carve-out? ☐ Yes ☐ No

Health Insurance Company	Contract Holder	Insurance Policy #	Group #	Name of Employer

NOTE: Certain restrictions apply to high deductible health plans. A summary plan description of the other coverage must be provided to document the deductible amount.

If choosing the State Employees' Supplemental Coverage Plan, you cannot maintain your primary coverage through BCBS Group 13000 (State Employees' Health Insurance Plan), Group 30000 (Local Government Health Insurance Plan), Group 14000 (Public Education Employees' Health Insurance Plan), Medicare, Medicaid, or the Marketplace.

If pharmacy benefits are administered by a company other than Blue Cross Blue Shield, you will need to manually file claims for pharmacy benefit reimbursements.

AFFIRMATION AND RELEASE

I hereby affirm that I have completely read and fully understand the terms and conditions of this form. I attest that all the representations made by me on this form are true and correct. I understand that any misrepresentation may result in the forfeiture of insurance coverage and that I will be personally liable for all claims related to such misrepresentation. I further understand that there is mandatory utilization review and I do hereby give permission to release any information necessary to evaluate, administer, and process claims for benefits to any person, entity, or representative acting on the State's behalf.

Signature: _____ Date: _____

General Information

Eligible Dependent

The term "dependent" includes the following individuals, subject to appropriate documentation (Social Security number, marriage certificate, birth certificate, court decree, etc.):

1. Your spouse (excludes divorced or common-law spouse).
2. A child under age 26, only if the child is:
   a. your son or daughter,
   b. a child legally adopted by you or your spouse,
   c. your stepchild.
3. Your grandchild, niece or nephew:
   a. under 19 years of age, and
   b. for whom the court has granted custody to you or your spouse.
4. An incapacitated dependent over age 25 will be considered for coverage provided dependent:
   a. is unmarried,
   b. is permanently mentally or physically disabled or incapacitated,
   c. is so incapacitated as to be incapable of self-sustaining employment,
   d. is dependent on you for 50% or more support,
   e. is otherwise eligible for coverage as a dependent except for age,
   f. the condition must have occurred prior to the dependent's 26th birthday, and
   g. is not eligible for any other group health insurance benefits.

Neither a reduction in work capacity nor inability to find employment is, of itself, evidence of eligibility. If a mentally or physically disabled dependent is working, despite his disability, the extent of his earning capacity will be evaluated.

To apply, contact the SEIB to obtain an Incapacitated Dependent Certification Form. Final approval of incapacitation will be determined by Medical Review. Proof of disability must be provided to the SEIB within 60 days from the date the child would cease to be covered because of age.

Exception: There are two situations under which it may be possible to add an incapacitated dependent who meets the eligibility requirements except for age:

1. When a new employee requests coverage for an incapacitated dependent within 60 days of employment; or
2. When an employee's incapacitated dependent is covered under a spouse's employer group health insurance for at least 18 consecutive months and:
   a. the employee's spouse loses the other coverage because:
      - spouse's employer ceases operations, or
      - spouse's loss of eligibility due to termination of employment or reduction of hours of employment, or
      - spouse's employer stopped contribution to coverage,
   b. a change form is submitted to the SEIB within 30 days of the incapacitated dependent's loss of other coverage, and
   c. Medical Review approved incapacitation status.

The above requirements must be met as a minimum threshold in order to be considered for incapacitation status. The SEIB shall make the final decision as to whether an application for incapacitated status will be accepted. NOTE: The SEIB reserves the right to periodically re-certify incapacitation.

In the event of the death of an active employee, who carried family coverage, the eligible dependents may continue coverage by making the appropriate premium payment to the SEIB. The SEIB must be notified within 90 days of the death.

Exclusion: You may not cover your spouse or other dependents if they are independently covered as a State employee.

STATE EMPLOYEES' INSURANCE BOARD
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