*Only for non-Medicare members enrolled in the State Employees' Health Insurance Plan - Group 13000

IB29 **10/16**

RE-ENROLLMENT FORM

Name (First, Middle Initial, Last)	Contract Number

Currently, you are enrolled in the State Employees' Health Insurance Plan (SEHIP) Group 13000 – the SEIB's group health insurance plan administered by Blue Cross Blue Shield of Alabama. Please review the information on the website which describes the other SEIB plans and enroll in one of the health insurance options by marking the appropriate box below.

Choose only one of the five boxes listed below and sign the form. If you choose more than one, or fail to sign, your enrollment form will be rejected and you will be required to submit a new form before your choice is effective. Any election will not be effective until you provide the documentation required by the SEIB.

☐ **State Employees' Supplemental Coverage Plan – Administered by Blue Cross Blue Shield of Alabama**
Required documentation: a copy of your Summary Plan Description of your other group health insurance (OGHI) showing the deductible amount.

Name of Primary Contract Holder	Name of Employer of Primary Contract Holder	Name of Primary Health Insurance Company	Primary Insurance Group Number	Primary Insurance Policy/Contract Number

☐ **Premium Cash Option -** Must be a full-time, active state employee

Name of Primary Contract Holder	Name of Employer of Primary Contract Holder	Name of Primary Health Insurance Company	Primary Insurance Group Number	Primary Insurance Policy/Contract Number

☐ **SEIB Optional Insurance Plan – Administered by Southland**

Name of Primary Contract Holder	Name of Employer of Primary Contract Holder	Name of Primary Health Insurance Company	Primary Insurance Group Number	Primary Insurance Policy/Contract Number

☐ **Keep State Employees' Health Insurance Plan – Group 13000 – Administered by Blue Cross Blue Shield of Alabama**

☐ **Decline all coverage – this option will disenroll you from medical coverage only. If you are enrolled in a dental, vision or cancer plan and select this option, those coverages will continue unless you submit a separate Dental/Vision/Cancer Insurance Enrollment/Cancellation Form (IB21, IB20, IB23).**

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 of Contract Holder Date

Fax completed form to (334) 263-8541.

Discrimination is Against the Law

The State Employees' Insurance Board (SEIB) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The SEIB does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The SEIB:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact 1-855-216-3144 or TTY: 711.

If you believe that the SEIB has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Section 1557 Coordinator, 201 South Union Street, Montgomery, Alabama, 36104; Direct: (334) 263-8413; Fax (334) 263-8711; Email: 1557Grievance@alseib.org. You can file a grievance by mail, fax, email or in person. If you need help filing a grievance, the Section 1557 Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Multi-Language Interpreter Services

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-216-3144 (TTY: 711).

Korean: 주 의 : 만 약 당 신 이 말 하 는 스 페 인 어 , 당 신 은 당 신 의 처 리 무 료 언 어 지 원 서 비 스 에 있 다 . 전 화 는 1-855-216-3144 (TTY: 711).

Chinese: 注意： 如果讲西班牙语，有免费的援助语言及其处置服务。调用 1-855-216-3144 (TTY: 711)。

Vietnamese: Chú ý: Nếu bạn nói tiếng Tây Ban Nha, bạn có lúc xử lý ngôn ngữ miễn phí dịch vụ hỗ trợ của bạn. Gọi đến 1-855-216-3144 (TTY: 711).

Arabic: تنبيـــــه: إذا كـان يتحـــدث الإســـــبانية، وفــي التخلـــص من خـدماتها بالمســـاعدة اللغويـــة. الـدعوة إلـى 1-855-216-3144 (TTY: 711).

German: Achtung: Wenn Sie Spanisch sprechen, müssen Sie Ihre kostenlose Hilfe Serviceleistungen zur Verfügung. Aufruf an die 1-855-216-3144 (TTY: 711).

French: ATTENTION : Si vous parlez espagnol, vous avez à votre disposition linguistique gratuite assistance services. Appel à la 1-855-216-3144 (ATS : 711).

Gujarati: ચુના: જો તમે જરાતી બોલતા હો, તો િ ન:લ્કુ ભાષા સહાય સેવાઓ તમારા માટ ઉપલબ્ધ છ. ફોન કરો 1-1-855-216-3144 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-216-3144 (TTY: 711).

Hindi: ध्यान दें: यदि स्पेनिश बोलते हैं, अपने निपटान पर सेवाओं की भाषाई सहायता नि: शुल्क है। 1-855-216-3144 कॉल (TTY: 711)।

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວ ້າພາສາ ລາວ, ານບໍລິການຊ່ວຍເຫ ຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-855-216-3144 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на испанском языке, вы имеете в вашем распоряжении бесплатные помощи услуги. Вызовите 1-855-216-3144 (TTY: 711).

Portuguese: Atenção: Se fala espanhol, tem em seus serviços de eliminação de assistência linguística. Ligue para o 1-855-216-3144 (TTY: 711).

Turkish: Dikkat: İspanyolca, elden çıkarma ücretsiz dil yardım hizmetlerinde varsa. Aramak için 1-855-216-3144 (TTY: 711).

Japanese: 注意: あなたがスペイン語を話す場合、あなたはあなたの処分無料言語アシスタンスサービスであります。1-855-216-3144 を呼び出す (TTY: 711)