

# ADMINISTRATIVE PROCEDURES GUIDE

**State Employees' Insurance Board**

**1.866.836.9737**

**334.263.8341**

**Fax: 334.263.8541**

**Post Office Box 304900  
Montgomery, Alabama 36130-4900**

**[www.alseib.org](http://www.alseib.org)**

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## **Introduction**

This Administrative Procedures Guide is designed to inform State agencies of the State Employees' Insurance Board's policies and procedures that must be followed when enrolling and dis-enrolling eligible employees in the plans offered by the Board. This Administrative Procedures Guide replaces any previously issued information. The State Employees' Insurance Board (SEIB) has absolute discretion and authority to interpret the terms and conditions of the plans and reserves the right to change the terms and conditions and/or end the plan at any time and for any reason.

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## **I. EMPLOYEE ELIGIBILITY & ENROLLMENT FOR STATE EMPLOYEES' HEALTH INSURANCE PLAN (SEHIP), SUPPLEMENTAL COVERAGE, AND OPTIONAL POLICIES (SOUTHLAND).**

### **A. Eligible Employee**

The term "employee" includes only:

1. Full-time State employees and employees of County Health Departments, who are paid by the State Comptroller, the State Department of Mental Health, Historic Blakely, Ft. Payne Improvement Authority, Historic Ironworks Commission, Bear Creek Development Authority, International Motor Sports Hall of Fame, Space and Rocket Center, the State Docks, St. Stephens Historical Commission, Alabama Sports Hall of Fame, USS Battleship, Red Mountain Greenway Commission and County Soil & Water Conservation Districts are to be eligible for coverage under this plan.
2. Part-time employees are only eligible for the Basic Medical Health Insurance Plan if they agree to have the required premium paid through payroll deduction.
3. Members of the Legislature and the Lieutenant Governor are eligible during their term of office (excluding optional and supplemental plans).

**Exclusion:** Coverage is not available for those classified on the State of Alabama's records as an employee employed on a seasonal, temporary, intermittent, emergency or contract basis.

### **B. 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 (including any probationary period during which the child is required to live with you),
  - c. your stepchild,
  - d. your grandchild, niece, or nephew for whom the court has granted custody to you or your spouse.

**(Exception:** children age 19 and older who are eligible for coverage through their employer are not eligible for coverage under SEHIP.)

3. 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 otherwise 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 wife, husband, or other dependents if they are independently covered as a State employee.

PCET's with ALDOT may remain dependents if their employment is part of their educational training.

### **C. Enrollment, Commencement and Reporting**

Upon enrollment coverage commences as stated below. The provisions on waiting periods for preexisting will apply. (See "Waiting Periods for Preexisting Conditions.")

#### **1. Employee**

- a. new employees who do not decline coverage will be enrolled as of the **effective date of employment**, subject to SEIB rules and procedures.
- b. the SEIB will bill the employer a pro rata premium for every new employee for the month in which his/her coverage begins.
- c. if the date of hire is between the 1<sup>st</sup> and 15<sup>th</sup>, the full individual premium will be deducted from the employee's first paycheck. If date of hire is between the 16<sup>th</sup> and 31<sup>st</sup>, half of the individual premium will be deducted from the first paycheck. Up to three months of the individual premium could be deducted from the first paycheck.
- d. an SEIB Health Insurance Enrollment Form must be completed by the employee and his/her employer and submitted to the SEIB.
- e. part-time employees may elect coverage to be effective on their date of employment, subject to appropriate premium payment, or on the first day of the month following first payroll deduction.

#### **2. Dependent**

When adding dependents to family coverage, you must submit appropriate documentation (Social Security number, marriage certificate, birth certificate, court decree, etc.) to the SEIB. NOTE: to avoid enrollment deadlines you should submit enrollment forms to the SEIB even if you do not have all of the appropriate documentation at the time of enrollment.

- a. New employees may elect to have dependent coverage begin on the date their coverage begins or no later than the first day of the second month following their effective date of coverage, subject to appropriate premium payments.
- b. Dependents may be added to your coverage only during the open enrollment period in November each year. Exception: dependents gained through birth, adoption or marriage may be added to your coverage during the plan year if you submit a change form to the State Employees' Insurance Board within 60 days of gaining a new dependent. (Special enrollment rights may apply for dependents that lose their other employer group coverage.)
- c. The new employee's enrollment form shall reflect the effective date for both the employee and dependent coverage. The SEIB may change the dependent's effective date, subject to receipt of documentation or premium payment.
- d. Payroll deduction for insurance is taken from the last paycheck of the month. A **direct payment** for dependent coverage premium must be submitted with the enrollment form for any coverage period before payroll deduction. The deduction from your payroll check or the deposit by the SEIB of your direct payment does not constitute acceptance of coverage.

**3. Part-time Employees**

a. Eligibility

- 1. Part-time employees are **only** eligible for State Employees' **Basic Medical** Health Insurance (SEHIP) coverage provided that such employees agree to pay, through payroll deduction, the portion of the full premium not paid by the State.
- 2. Full-time employees enrolled in any of the supplemental plans, who go part-time, must either decline coverage or revert back to basic medical plan and pay portion of the funding rate.
- 3. The schedule shown below is used to determine the pro rata premium to be paid by the State and the employee:

Employment Status	State Portion of Funding Rate	Employee Portion of Funding Rate
Less than ½ time	25%	75% + employee premium
At least ½ time but less than ¾ time	50%	50% + employee premium
At least ¾ time but less than full time	75%	25% + employee premium
Full time	100%	0% + employee premium

b. Determination of Status

- 1. Determination of employment status is the responsibility of the employer; however, such status shall be subject to periodic review by the SEIB. A copy of Form 11 or a memo providing the SEIB with date and percentages of part-time status is required.
  - a) such reviews will consider the rate of pay and hours worked in determining the employment status of any part-time employee;
  - b) employers will be advised on any status questioned by the SEIB and will be required to revise or certify the status reported.
- 2. The employment status in effect on the first day of the month shall apply throughout that month for insurance purposes.
- 3. Changes in employment status that result in a change in pro rata premium payments will become effective on the first day of the following month.
- 4. Changes in employment status should be reported to the SEIB on a Form 11 or with a memo.

c. Termination of Coverage

Individuals whose employment status changes from full-time to part-time will not automatically be payroll coded for **no** insurance merely because their employment status changed to part-time. If an employee elects not to be covered while a part-time employee, a Membership Status Change Form should be completed requesting coverage cancellation. Do not use the "decline coverage" option on the enrollment form.

Until the "drop coverage" notification is received, the enrollment for initiating coverage is still in effect, and therefore, the appropriate payroll deduction will be made in order to continue the coverage.

d. Enrollment

1. Part-time employees who do not elect coverage to be effective on their date of employment or first day of month following first payroll deduction may enroll only during annual open enrollment.
2. Enrollment forms for part-time employees should indicate the employment status but otherwise should be completed in the same manner as enrollment forms for full-time employees.

**D. Waiting Periods for Preexisting Medical Conditions**

Each member must serve a waiting period of 270 consecutive days before benefits for "pre-existing medical conditions" are available. The 270-day waiting period begins with the member's effective date. The entire 270-day waiting period must be served before the member receives services or supplies or is admitted to the hospital for preexisting medical conditions. **NOTE:** The 270-day waiting period does not apply to pregnancy, and members under age 19.

A "pre-existing medical condition" is any condition, no matter how caused, for which a member received medical advice, diagnosis, care, or for which treatment was recommended or received during the six months before his/her coverage began.

**Credit for Prior Coverage (The Health Insurance Portability and Accountability Act):** If a member is covered by another plan before becoming covered by SEHIP, the time they were covered will be credited toward the 270-day waiting period for preexisting medical conditions, if:

1. there is no greater than a 63 day break in coverage, and
2. the last coverage was "creditable coverage," i.e., under an individual or group health plan including COBRA, Medicare, Medicaid, U. S. Military, TRICARE, Federal Employee Program, Indian Health Service, Peace Corps Service, a state risk pool or a public health service.

The member may request a copy of a Certificate of Creditable Coverage from their previous carrier. The certificate will show the date on which coverage began and ended. In order to request a copy of a Certificate of Creditable Coverage, the member must call or write their previous carrier no later than 24 months after the date on which their coverage ceases.

**E. Transfers**

1. Transfers from any other health insurance plan (including those of the Claims Administrator) will be required to serve the 270-day waiting period less any "creditable coverage" as described in Section D, 2.
2. Insurance coverage for an employee who transfers from one State agency to another will be paid by the agency which pays the employee on the insurance payday received on the 1<sup>st</sup> of the month. Example: last day with Revenue Department August 9; begins with Public Safety August 20. Insurance pay period is with Revenue Department to pay for September coverage.
3. An employee may add coverage for a dependent when the dependent ceases to be a State employee. Dependent coverage for the former State employee must begin on the day following the final day of coverage for the dependent as a State employee. For example, a State employee

whose wife terminates State employment on January 8 must add dependent coverage to be effective February 1, since his wife will be covered as an employee through the end of January.

#### **F. Open Enrollment**

1. Annual open enrollment shall be held in November of each year for coverage to be effective January 1.
2. Open enrollment shall apply to active or retired subscribers who wish to change plans, begin coverage, add dependent coverage or add a dependent to existing family coverage.
3. The waiting period for preexisting conditions shall not be waived during open enrollment. Exception: members under age 19.

#### **G. Special Enrollment**

Alabama law allows active full-time employees to decline coverage in the SEHIP. The Health Insurance Portability and Accountability Act of 1996 requires that a special enrollment period be provided in addition to the regular enrollment period for employees and eligible dependents if:

1. the employee declined to enroll in the SEHIP because of other employer group coverage and submitted a completed "Declination of Coverage"; and
2. the employee gains a new dependent through marriage, birth or adoption; or
3. the employee or dependent loses the other employer group coverage because:
  - a. COBRA coverage (if elected) is exhausted, or
  - b. loss of eligibility (including separation, divorce, death, termination of employment or reduction of hours of employment), or
  - c. employer stopped contribution to coverage; and,
4. the employee requests enrollment in the SEHIP in writing no later than 30 days after the loss of other coverage.

#### **H. Active Employee Over 65**

Active employees and their dependents over age 65 are covered under the same conditions as any employee under age 65. The SEHIP remains primary for services until employee retires.

#### **I. Status Changes**

A status change form should be completed for addition or deletion of dependent coverage. The status change must be submitted directly to the SEIB by mail, fax or by visiting the SEIB website at [www.alseib.org](http://www.alseib.org).

#### **J. Address Changes**

To change an address, a written request must be submitted to the SEIB office at Post Office Box 304900, Montgomery, AL 36130-4900. An address cannot be updated by Blue Cross and Blue Shield of Alabama or made from information shown on claim forms. Employees may also update their address online at [www.alseib.org](http://www.alseib.org).

#### **K. Employee Name Changes**

Name changes are processed electronically once they are changed on payroll with the employee's agency.

## **II. TERMINATION OF COVERAGE**

#### **A. When Coverage Terminates**

Coverage under this plan will terminate:

1. On the last day of the month in which employment terminates. The SEIB may continue an employee's coverage if the employee is absent from work because of injury or sickness, or if the employee is absent from work due to leave of absence or temporary layoff, but only for a limited period. Premiums may be required from the employee by direct pay. For details, contact the SEIB.
2. When this plan is discontinued.

Coverage under this plan will also terminate for a dependent:

1. On first day of the following month in which such person ceased to be an eligible dependent.
2. If the dependent becomes covered as an employee.
3. When premium payments cease.

In many cases the employee will have the option to choose continuation of group benefits as provided by the Public Health Service Act. (See COBRA Section in Employee handbook.)

## **B. Family & Medical Leave Act**

The SEIB will adhere to the provisions of the Family and Medical Leave Act as approved by the appropriate authority. The Family and Medical Leave Act of 1993, which became effective August 5, 1993, requires state departments and agencies to continue health insurance coverage for employees on FMLA. Procedures for payment of health insurance premiums for employees on FMLA are as follows:

1. Employees who are in pay status while on FMLA (i.e. using annual or sick leave), will continue to have the employee and dependent health insurance premiums paid through the GHRS payroll/personnel system by the State Comptroller.
2. Those employees on FMLA who are not in pay status when health insurance premiums are deducted will be responsible for paying their premiums directly to the SEIB if they want to continue the health insurance coverage.

The Board requests that the agency inform all employees who request FMLA of these procedures. Also, especially remind those employees on FMLA who want to continue coverage, they must ensure that their premiums are paid continuously every month. If they do not receive a paycheck when premiums are normally deducted, they must make the payment directly to the SEIB; otherwise, the health insurance coverage will be canceled.

3. Documentation (Form 11) of FMLA on employees not in pay status should be sent to SEIB. The GHRS payroll is not an automated billing system for FMLA insurance premiums. When SEIB is notified they will check to see premiums due are billed and paid. SEIB should also be notified when employees return to pay status.

## **C. Employees on Leave without Pay (LWOP)**

1. **State health insurance coverage for employees on official leave without pay** may be continued for a maximum of 12 months provided the employee elects to make the premium payment required for coverage directly to the Board. Official leave without pay is established when an employee has received the approval of the Personnel Department (for classified employees) or appointing authority, where applicable, to be taken off the payroll for an extended period of time.
2. **Direct Payment of Premiums for Employees on Leave:** The employer share of premiums for employees going on leave without pay will be paid by the employer for the month in which leave without pay begins unless leave begins on the first of the month, in which case the employee must make the premium payment. For example, an employee beginning leave on March 10 will begin direct payment April 1 (the employer would pay the employer share for March coverage). Therefore, the first direct payment and documentation of leave without pay must be received by the Insurance Board no later than April 1. If leave began March 1, the employee would pay for March coverage.

3. **Documentation of Leave Status:** Direct payments will **not** be processed without proper documentation indicating that the employee is on official leave (Form 11 for classified employees, documentation from appointing authority for others). The first direct payment must be accompanied by a copy of the documentation of official leave and both the payment and the documentation must be received no later than the first day of the coverage period for which direct payment is submitted. Employees covered under the State Employees' Supplemental Plan or the Optional Plans will be required to pay premiums.
  - Employee enrolled in SEHIP pay 100% of funding rate plus the employee premium.
  - Employees enrolled in supplemental plan or optional policies pay 20% of funding rate (no employee premium).
4. **Return from Leave without Pay:** If the employee maintained coverage through direct payment, the employee will be responsible for payment of premiums through the end of the month in which he/she returns to active employment unless they return on the first working day of the month. The employing agency must resume payment of employer share of premiums beginning with the month immediately following the month in which the employee returns. For example, an employee who returns from leave on March 8 must pay for his/her March coverage. The employer would resume payment of the employer share of premiums beginning with the April coverage. No pro rata premiums will be accepted unless the employee did **not** make direct payment of premiums while on leave, in which case the employee is considered a new employee for insurance purposes and must be re-enrolled on the date the employee returns to active employment. A new enrollment and pro rata payment is required, (the 270-day preexisting condition limitation will apply if there is more than a 63-day break in coverage).
5. **Periods Off Payroll Not Considered Official Leave Without Pay:** When an employee has depleted his/her accumulated leave and must be taken off the payroll for several days, payment of the employer share of premium should be continued by the employing agency if the period off the payroll is not considered extended leave without pay requiring approval of the Personnel Department (for classified employees) or appointing authority where applicable.

#### **D. Continuation of Group Health Coverage (COBRA)**

The Public Health Service Act [42 USC Sections 300bb-1 through 300bb-8] requires that the SEIB offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end.

#### **E. Workers' Comp - Premiums for Employees Who Suffer a Work-Related Injury**

Agencies and departments will continue to be responsible for paying the employer's share of premiums for their employees who have reported a work-related injury to the State Employees' Injury Compensation Trust Fund (SEICTF). If the injured employee has opted to take the 2/3's wage replacement, agencies and departments are encouraged to maintain the employee's GHRS health insurance codes to pay the employer's share of premiums. Otherwise, premiums for these employees will be included in the monthly billing to the agencies and departments. The SEIB will not bill nor accept payment for the employer's share of premiums from the employee.

Injured employees, who do not have their share of premiums deducted through payroll, will be responsible for paying the premiums directly to the SEIB. If premiums are not received before or during the month of coverage, the employee's coverage will be canceled.

#### **F. Refund Request**

1. All requests for refund of SEHIP premiums should be submitted by using the Refund Request form which is provided by the SEIB.
2. The refund request form was designed to be used for both refunds made to the department and employees. Refunds will be sent to the department for any premiums paid through payroll deduction.

3. For detailed instructions for employer and employee share of health insurance refunds, please go to [www.sbs.alabama.gov](http://www.sbs.alabama.gov)., click on the **“AFNS Agency Assistance”** tab at the top, click on **Training Material** on the left hand side of the page, and look under the title **Salary Overpayment Refunds-Insurance.**

### **III. RETIREE ELIGIBILITY & ENROLLMENT FOR STATE EMPLOYEES’ HEALTH INSURANCE STATE EMPLOYEES SUPPLEMENTAL COVERAGE, OR STATE EMPLOYEES OPTIONAL POLICIES**

#### **A. Eligible Retired State Employee**

A retired employee of the State of Alabama who has at least 10 years of creditable coverage in the SEHIP and receives a monthly benefit from the Employees' Retirement System or Teachers' Retirement System of Alabama or Judicial Retirement System.

#### **B. Eligible Dependent - see page 5.**

#### **C. Enrollment/Continuation**

1. A retiring employee may elect coverage under the State Employees' Health Insurance, by agreeing to have the monthly premium amount (if applicable) deducted from his retirement check.
2. A Medicare retiree and/or a Medicare dependent should have both Medicare Parts A and B to have adequate coverage with the State of Alabama. Medicare Part B premiums are the retiree's responsibility. These premiums are deducted from the retiree's Social Security check.
3. Miscellaneous insurance premium direct payments are not accepted. These premiums will be deducted from the retirement check upon receipt of notification from each company.

#### **D. Open Enrollment**

Retired employees that do not elect to continue their coverage under the SEHIP may do so during the annual open enrollment held each November for coverage to be effective January 1. Waiting periods for pre-existing conditions shall not be waived during open enrollment without proof of prior coverage.

#### **E. Survivor Enrollment**

In the event of the death of a retired employee, who carried family coverage, the eligible dependents may continue coverage by making appropriate premium payments to the SEIB. The SEIB should be notified within 90 days of the date of death.

#### **F. Employees Retired after September 30, 2005, but Before January 1, 2012 - Premium Based on Years of Service**

If you retired after September 30, 2005, but before January 1, 2012, you will be subject to a sliding scale premium structure based on your years of State service. The premium for retiree coverage is broken down into the “employer contribution” and the “employee contribution.” The dollar amount of these contributions is subject to change each year.

Under the sliding scale, the retiree will still be responsible for the “employee contribution” of the premium, however, the amount the State will pay toward the “employer contribution” of the premium will increase or decrease based upon a retiree's years of State service. For those employees retiring with 25 years of State service, the State would pay 100% of the “employer contribution” of the premium. Each year less than 25, the amount the State will pay toward the “employer contribution” would be reduced by 2% and the “employee contribution” will be increased accordingly. Each year over 25, the amount the State pays toward the “employer contribution” would be increased by 2% and the employee contribution reduced accordingly. NOTE: The retiree sliding scale is not applicable to the non-tobacco user premium discount.

Years of creditable service are determined by the Retirement Systems of Alabama. Effective for all employees retiring after July 31, 2008, Act 2008-280 authorizes the SEIB to exclude from RSA's years of creditable service calculation any service not related to service as a State employee (as defined in Section 36-29-1 Code of Alabama 1974) except for creditable service related to the following:

- service in the United States armed forces, or
- service as an employee as defined in Sections 16-25A-1 and 16-25A-11 Code of Alabama 1974, or
- service as an employee of a postsecondary institution eligible for PEEHIP coverage as a retiree.

#### **Employees Retired on or after January 1, 2012 - Premium Based on Years of Creditable Coverage in the SEHIP**

If you retired on or after January 1, 2012, you will be subject to a sliding scale premium structure based on your years of creditable coverage in the SEHIP. The premium for retiree coverage is broken down into the "employer contribution" and the "employee contribution." The dollar amount of these shares is subject to change each year.

Under the sliding scale, the retiree will still be responsible for the "employee contribution" of the premium, however, the amount the State will pay toward the "employer contribution" of the premium will increase or decrease based upon a retiree's years of creditable coverage in the SEHIP. For those employees retiring with 25 years of creditable coverage in the SEHIP, the State would pay 100% of the "employer contribution" of the premium. Each year less than 25, the amount the State will pay toward the "employer contribution" would be reduced by 4% and the "employee contribution" will be increased accordingly. Each year over 25, the amount the State pays toward the "employer contribution" would be increased by 2% and the employee contribution reduced accordingly. NOTE: The retiree sliding scale is not applicable to the non-tobacco user premium discount.

Years of creditable coverage in the SEHIP are determined by the SEIB. Creditable coverage may be allowed for the following service time:

- service in the United States armed forces, or
- service as an employee as defined in Sections 16-25A-1 and 16-25A-11 Code of Alabama 1974, or
- service as an employee of a postsecondary institution eligible for PEEHIP coverage as a retiree, provided the postsecondary institution contributes an amount equal to the amount appropriated by the state to fund benefits for such retired employees.

#### **Employees Retired on or after January 1, 2012, Without Medicare - Premium Based on Years of Creditable Coverage in the SEHIP and Age at Retirement**

In addition to the changes in the retiree sliding scale, employees retired on or after January 1, 2012, without Medicare will also be subject to an additional premium based on age at retirement. The employer contribution of the retiree sliding scale premium will be reduced by 1% for every year of age of employee at retirement less than the Medicare entitlement age. This percentage will remain the same each year until entitlement to Medicare. Upon Medicare entitlement, the percentage deduction of the state contribution will be removed. (Most people are entitled to Medicare at age 65 or earlier if disabled.)

#### **Deferred Retirement Option Plan (DROP)**

The new sliding scale premium effective for employees retired on or after January 1, 2012, will not apply to employees who have elected to participate in the Deferred Retirement Option Plan (DROP) if the DROP participant:

1. does not voluntarily terminate participation in the DROP within the first three years and
2. withdraws from service at the end of the DROP participation period.

This will exempt employees who entered the DROP from being subject to the new sliding scale premium if they do not voluntarily exit the DROP within the first three years and withdraw from service at the end of the DROP participation period.

#### **Disability Retirement on or after January 1, 2012 – Exemption**

Employees who retire on disability on or after January 1, 2012 are exempt from the retiree sliding scale premium calculation for a period of two years, provided the retiree applies for Social Security disability. To obtain the two-year exemption, the retiree must submit documentation from the Social Security Administration acknowledging the retiree's application for disability benefits.

To maintain the exemption after two years the retiree must be approved for Social Security disability. If the retiree fails to obtain Social Security disability within two years from retirement the retiree permanently loses the eligibility for this exemption.

Employees who retire on disability on or after January 1, 2012 are not exempt from the retiree sliding scale premium calculation based on age.

#### **G. Retiree Other Coverage**

If the employee retires after September 30, 2005, and goes to work for another employer, the retiree may be required to enroll in the other employer's health insurance plan. If the retiree is eligible for coverage in the new employer's health insurance plan and the new employer contributes 50% or more of the individual premium, the retiree will be required to drop the SEHIP as their primary coverage and enroll in the new health plan. The SEIB will offer the retiree supplemental coverage or optional coverage to cover most of their out-of-pocket expenses.

Special Enrollment is available for retirees who lose their other employer's group health plan coverage.

#### **H. Re-Employed State Retiree**

To comply with the Medicare, Medicaid and SCHIP Expansion Act, SEIB has to show that it is the primary payer for all employees covered by the SEHIP, including re-employed Medicare retirees. This applies to all re-employed State retirees with a FICA deduction.

All re-employed State retirees must complete a Re-employed State Retiree Health Insurance Form.

If the employee and/or dependent are Medicare eligible, SEHIP will be the primary payer and premiums will be adjusted. SEIB will bill the State agency for the employer premiums on the monthly supplemental billing. The base premium for re-employed State Medicare retirees will be the non-Medicare retiree premium, plus or minus the sliding scale adjustment if applicable.

Dependent premiums for re-employed State retirees will be paid by the retiree through the monthly deduction from their retirement check.

Non-Medicare re-employed State retirees will continue to pay their premiums through their retirement check.

It is very important that the SEIB is notified by Form 11 (or a memo) when the re-employed State retiree is no longer employed, so that the SEIB can change the coverage back to Medicare when applicable.

#### **I. Special Enrollment**

The Health Insurance Portability and Accountability Act of 1996 requires that a special enrollment period be provided in addition to the regular enrollment period for retired employees and eligible dependents if:

1. the retired employee declined to enroll in the SEHIP because of other coverage and submitted a completed "Declination of Coverage;" and
2. the retiree gains a new dependent through marriage, birth or adoption; or
3. the retiree or dependent loses the other employer group coverage because:
  - a. COBRA coverage (if elected) is exhausted, or
  - b. loss of eligibility (including separation, divorce, death, termination of employment or reduction of hours of employment), or
  - c. employer stopped contribution to coverage; and,
4. the retiree requests enrollment in the SEHIP in writing no later than 30 days after the loss of other coverage.

## IV. EMPLOYEE OPTIONS TO SEHIP

### A. Optional Plans

#### 1. Employee Opt-Out Provision

Employees may decline coverage in the SEHIP by submitting an enrollment form to SEIB for approval. The agency is still required to pay the Employer Premium for those who decline coverage in the SEHIP.

Employees who decline coverage may reenroll during the regular Open Enrollment period. Special Enrollment is available for all employees who lose their other employer group health coverage, subject to the rules and procedures established by the SEIB.

A full time employee of the State of Alabama may not be covered as a dependent under the SEHIP.

#### 2. State Employees' Supplemental Coverage Plan (No dependent documentation required.)

Employees who decline coverage in the SEHIP may enroll in the State Employees' Supplemental Coverage Plan at no cost to the employee. The State Employees' Supplemental Coverage Plan will provide secondary benefits to the employee's and non-Medicare retiree's primary coverage provided by another employer. Employee *must* provide SEIB with primary coverage information. The State Employees' Supplemental Coverage Plan benefits cover deductibles, copayments, and coinsurance per their primary coverage plan benefits. Participants may elect individual or family coverage.

Employees who enroll in the State Employees' Supplemental Coverage Plan may drop this coverage and re-enroll in the SEHIP at any time. Coverage will be effective no later than the first day of the second month following receipt and approval of an enrollment form by the SEIB.

Employees who decline coverage in the SEHIP and enroll in the State Employees' Supplemental Coverage Plan may not enroll in the SEIB Optional Insurance Plan.

The primary coverage cannot be with SEHIP, PEEHIP, LGHIP, TRICARE or Medicare.

An employee may not be added as a dependent under another employee's SEHIP coverage regardless of whether he or she has declined coverage in the SEHIP.

#### 3. SEIB Optional Insurance Plan (No dependent documentation required.)

Employees who decline coverage in the SEHIP may enroll in the SEIB Optional Insurance Plan. The SEIB Optional Insurance Plan offers four supplemental policies: Dental, Cancer, Hospital Indemnity and Vision. The four policies are offered as a package at no premium to the employee. Participants may elect individual or family coverage.

An eligible employee or retiree may enroll in the SEIB Optional Insurance Plan at any time, subject to SEIB rules and procedures, by submitting a completed enrollment form directly to the SEIB. Participants must remain in the SEIB Optional Insurance Plan for at least twelve months.

Open and Special Enrollment back into the SEHIP is available for all eligible employees and retirees subject to SEIB rules and procedures.

Employees who decline coverage in the SEHIP and enroll in the SEIB Optional Insurance Plan may not enroll in the State Employees' Supplemental Coverage Plan.

An employee of the State of Alabama may not be covered as a dependent under the SEHIP.

### B. Optional Discounts

#### 1. Federal Poverty Level Discount Program

If an employee's combined family income is less than or equal to 300% of the Federal Poverty Level as defined by the federal law, he/she may be eligible for a percentage discount off the approved

premium. In order for employees and retirees enrolled in the SEHIP to qualify for the discount, acceptable proof of total family income must be submitted to the SEIB.

Family income will be determined based upon current income in conjunction with the prior year's federal and state income tax returns. As a condition of participating in the Federal Poverty Level Discount Program, applicants must authorize the Alabama Department of Revenue (or the appropriate agency of the applicant's state of residence) to release to the SEIB all of the applicant's tax related information in their records for the current and prior tax year.

The premium discount will be applied as follows:

Greater than 300% of the FPL – employee pays 100% of the employee contribution  
Equal to or less than 300% of the FPL – employee contribution reduced 10%  
Equal to or less than 250% of the FPL – employee contribution reduced 20%  
Equal to or less than 200% of the FPL – employee contribution reduced 30%  
Equal to or less than 150% of the FPL – employee contribution reduced 40%  
Equal to or less than 100% of the FPL – employee contribution reduced 50%

Certification of income level will be effective for twelve months. Thereafter, re-certification will be made annually on the employee's or retiree's birthday.

The Federal Poverty Level discount will not apply to COBRA, or surviving spouse (INS, BEN) premiums.

Employees who have discounted premiums through the Federal Poverty Discount program may continue under this program while on approved leave without pay provided they qualified prior to going on leave without pay.

## 2. **Non-Tobacco User Discount Program**

If an employee (and employee's spouse if covered as a dependent under SEHIP) have not used tobacco products in the last twelve months, he/she may be eligible for a premium discount. In order to obtain the discount the employee must submit a completed non-tobacco user premium discount application to the SEIB. Employee may also qualify for the discount if he/she submits acceptable documentation to the SEIB each year verifying that employee (and employee spouse if covered as a dependent under SEHIP):

- have completed an SEIB approved tobacco usage cessation program; or
- cannot stop using tobacco products as advised by their physician because it is unreasonably difficult due to a medical condition.

New employees will have 60 days from date of hire to apply for the non-tobacco user discount. When a spouse is added, the 60-day period will also apply.

Refunds will not be allowed for failure to submit an acceptable certification form.

## 3. **Wellness Premium Discount**

All active employees are eligible for a wellness premium discount. Subject to the limitations listed below, each plan year every active employee must be screened either through the SEIB's worksite wellness screening or by a healthcare provider (through the submission of a physician's certification form) for the following health risk factors:

- Blood Pressure
- Total Cholesterol
- Glucose
- Body Mass Index

You will be deemed to be at risk for one or more of these health risk factors if your:

- Blood pressure systolic reading is equal to or above 160 or your diastolic readings is equal to or above 100,
- Cholesterol reading is equal to or above 250,

- Glucose reading is equal to or above 200,
- Body mass index is equal to or above 35.

Employees who are deemed at risk for any of the above health risk factors may be eligible for an office visit referral copay waiver.

In order to receive the wellness premium discount within a given plan year, employees have three options:

1. Submission of health risk factor readings through worksite wellness program, all of which are within the risk criteria. or
2. Submission of health risk factor readings through worksite wellness program where one or more of the health risk factors are outside the risk criteria and the employee:
  - a. submits a statement from employee's healthcare provider stating that employee has been counseled regarding the health risk factor(s); or
  - b. verifies participation in a Weight Watchers, YMCA or other SEIB approved program; or
  - c. provides a subsequent health risk factor reading(s) that the SEIB deems to be an improvement over previous aberrant reading(s). or
3. Submission of a completed physician certification form.

**Exception:** An employee may also receive the wellness premium discount if it is deemed that the employee cannot participate in the Wellness program due to pregnancy, disability or other infirmity as documented by the employee's physician.

The effective date of the wellness premium discount depends on when the screening results and/or other required documentation are submitted to the SEIB. However, in order for the wellness premium discount to be effective on January 1 (provided that the criteria listed above are met), you must be screened no later than November 30 of the preceding year.

New employees will have 60 days from date of hire to apply for the wellness premium discount.



## **ENROLLMENT FORM USES**

To enroll new employees

To re-enroll employees returning from LWOP

To decline coverage for new employees

## **NON-TOBACCO USER DISCOUNT APPLICATION USE**

Use this form to apply for the discount.

## **PROVIDER'S SCREENING FORM**

Use to apply for the discount.

## **WELLNESS CERTIFICATION FORM**

Use to apply for the discount.

## **SALARY REDUCTION AGREEMENT**

Use for new employees to opt out of dependent premium conversion plan.

Also use for employees to enroll and opt out for open enrollment only.





# State Employees' Health Insurance Plan

## 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 (including any probationary period during which the child is required to live with you),
  - c. your stepchild,
  - d. your grandchild, niece, or nephew for whom the court has granted custody to you or your spouse.

(Exception: children age 19 and older who are eligible for coverage through their employer are not eligible for coverage under SEHIP.)

3. 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 otherwise 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 wife, husband, or other dependents if they are independently covered as a State employee.

**STATE EMPLOYEES' INSURANCE BOARD  
NON-TOBACCO USER DISCOUNT APPLICATION**

<b>CONTRACT HOLDER NAME: (please print)</b>	<b>SOCIAL SECURITY NUMBER #:</b>
<b>E-MAIL ADDRESS:</b>	

**Declaration**

I declare that I am not currently using or have used tobacco products in any form (cigarettes, cigars, pipe, oral tobacco products, etc.) within the last 12 months.

If my spouse is covered as a dependent under the State Employees' Health Insurance Plan (SEHIP), I declare further that my spouse is not currently using or has used tobacco products in any form within the last 12 months.

I understand that if it is determined that I (or my spouse if covered as a dependent under the SEHIP) have used tobacco products within the last 12 months or if I (or my spouse if covered as a dependent under the SEHIP) start using tobacco products subsequent to the date of this application without notifying the State Employees' Insurance Board, that I will be subject to disciplinary action, including termination of employment, and will be required to repay all discounts as well as all claims and other expenses incurred by the SEHIP, plus interest.

**Signed:** \_\_\_\_\_  
Contract Holder

**Date:** \_\_\_\_\_

**Authorization**

By signing below, I/we hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medically related facility, insurance company, any government agency or other organization or person that has any records or knowledge of my health to provide to the State Employees' Insurance Board any information related to my/our use of tobacco products.

**Signed:** \_\_\_\_\_  
Contract Holder

**Date:** \_\_\_\_\_

**Signed:** \_\_\_\_\_  
Spouse (if covered under SEHIP)

**Date:** \_\_\_\_\_

Return to: State Employees' Insurance Board  
201 South Union Street, Suite 200  
Post Office Box 304900  
Montgomery, AL 36130-4900  
334.263.8341 / 1.866.836.9737 / Fax: 334.263.8541



## State Employees' Insurance Board Provider Screening Form

**Instructions:** If you cannot or choose not to participate in SEIB's Worksite Wellness screenings, you may submit your health screening results through your physician. You are to complete Section 1 of the form and your provider is to complete Section 2. In order to be eligible for the wellness premium discount, this form should be returned to the SEIB no later than 60 days of date of hire. Refunds are not allowed.

### SECTION 1 (To Be Completed by Employee)

<b>Member Name (Please print)</b>	<b>Screening Date</b>	<b>Male</b> <input type="checkbox"/> <b>Female</b> <input type="checkbox"/>	<b>Age:</b> _____
<b>Contract Number</b>	<b>Social Security Number</b>	<b>Date of Birth (00/00/00)</b>	<b>Day Time Phone Number</b> (    )

**What best describes your race/ethnicity?**

- White                       Black/African American                       Asian                       Indian or Alaska Native  
 Hispanic/Latino                       Native Hawaiian/Pacific Islander                       Other

**Do you have (or have you been told you had) any of the following? (Mark all that apply.)**

- High Cholesterol     High Blood Pressure                       Diabetes

**Do you take Medication for any of the following? (Mark all that apply.)**

- High Cholesterol     High Blood Pressure                       Diabetes

### SECTION 2 (To Be Completed by Provider)

<b>Blood Pressure</b> _____ / _____ <b>Total Cholesterol</b> _____ mg/dL <b>HDL Cholesterol</b> _____ mg/dL <b>LDL Cholesterol</b> _____ mg/dL <b>Triglycerides</b> _____ mg/dL <b>Blood Glucose</b> _____ mg/dl	<b>Height</b> _____ ft. _____ in <b>Weight</b> _____ <b>BMI</b> _____ <b>Waist Measurement</b> _____ in <b>HT/Waist Ratio</b> _____
---	---

**Provider's Name: (Please print)** \_\_\_\_\_

**Provider Signature:** \_\_\_\_\_

**Provider Address:** \_\_\_\_\_

**Please return completed form to:  
 STATE EMPLOYEES' INSURANCE BOARD  
 P O BOX 304900  
 MONTGOMERY AL 36130-4900  
 1.866.838.3059 FAX: 334.263.8631**



# State Employees' Insurance Board State Employees' Health Insurance Plan Wellness Discount Certification Form

Member Name (Please print)		Male <input type="checkbox"/>	Age: _____
		Female <input type="checkbox"/>	
Contract Number	Social Security #	Date of Birth (00/00/00)	Day Time Phone Number (     )

I have participated in a worksite wellness screening and one or more of the following health risk(s) have been identified.

- blood pressure systolic reading of 160 or higher, or diastolic reading of 100 or above;
- total cholesterol reading equal to or above 250;
- glucose reading equal to or above 200;
- body mass index equal to or above 35.

Regardless of your identified health risk(s), you can qualify for the wellness premium discount by certifying that you have completed one of the requirements below;

- I was counseled by my healthcare provider regarding the health risk(s) identified in my wellness screening results and I have attached one of the following:
  - Wellness Program Office Visit Referral that has been signed by my healthcare provider, or
  - Completed Provider Screening Form documenting my results.

- I participated in at least 12 weeks of a 15-week Weight Watchers program.

Location of program \_\_\_\_\_

Date(s) I attended \_\_\_\_\_

- I participated in a YMCA wellness program.

Location of program \_\_\_\_\_

Date(s) I attended \_\_\_\_\_

Program description \_\_\_\_\_ (i.e.: aerobics)

- I am self-managing my identified health risk(s). Attached is valid proof that I have made improvement in my identified health risk(s). **NOTE:** you must have made improvement in all identified risk(s) in order to continue your discount.

**This information must be received in our office no later than November 30.  
Incomplete forms will be returned.**

**Please return completed form to:  
STATE EMPLOYEES' INSURANCE BOARD  
P O BOX 304900  
MONTGOMERY AL 36130-4900  
1.866.838.3059  
FAX: 334.263.8631**



## New Employee – Open Enrollment

### Salary Reduction Agreement Dependent Premium Conversion Plan

**This form allows you to enroll and/or opt out of the Dependent Premium Conversion Plan, during Open Enrollment only.**

#### Employee Information

(please print)

Name:	Social Security Number:
Address:	City, State, Zip:
Work Telephone Number: (        ) _____	Home Telephone Number: (        ) _____

- I elect to enroll in the Dependent Premium Conversion Plan. I authorize the State to redirect a part of my salary to pay premiums with pretax dollars for dependent premiums.
- I do not elect to enroll in the Dependent Premium Conversion Plan.

#### Terms and Conditions

I understand that:

I cannot change or revoke any of my elections on the salary reduction agreement at any time during the Plan Year (January 1 – December 31) unless I have a change in family status.

During open enrollment of each plan year, I will be offered the opportunity to change my benefit elections for the following Plan Year. If I do not complete and return a new election form at that time, I will be treated as having elected to continue my benefit elections then in effect for the new Plan Year.

If my required contributions to pay premiums for the elected benefits are increased or decreased while this agreement remains in effect, my compensation redirection will automatically be adjusted to reflect that increase or decrease.

The Flexible Employees' Benefits Board may redirect or cancel my compensation redirection or otherwise modify this agreement in order to satisfy certain provisions of the Internal Revenue Service.

This Agreement is subject to the terms of the Flexible Benefits Plan, as amended.

#### Certification

**I hereby certify that I have completely read and fully understand the terms and conditions of this form.**

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date



## **SOUTHLAND NATIONAL VISION ENROLLMENT FORM**

To enroll new employees in vision coverage.

To enroll/cancel during Open Enrollment.



# State Employees' Insurance Board

## Southland National Supplemental Vision Insurance

### Enrollment/Cancellation Form

**SUBSCRIBER INFORMATION**

Name (First, Middle Initial, Last)		Sex	Effective Date (Must be on the 1 <sup>st</sup> day of the month)  / /
Social Security Number		Date of Birth	<input type="checkbox"/> Vision (Monthly premium \$24)  <b>A minimum enrollment of 12 months required for employees/dependents</b>  <input type="checkbox"/> Single Coverage  <input type="checkbox"/> Family Coverage (List dependents below.)  <input type="checkbox"/> Cancel Coverage
Mailing Address			
City	State	ZIP Code	
Home Telephone Number  ( )	Work Telephone Number  ( )		Ext:

E-mail Address:

First Name	Initial	Last Name	(Documentation is Required) Relationship to Employee		Date of Birth	Social Security Number
			<input type="checkbox"/> Husband	<input type="checkbox"/> Wife		
			<input type="checkbox"/> Son <input type="checkbox"/> Stepson	<input type="checkbox"/> Daughter <input type="checkbox"/> Stepdaughter		
			<input type="checkbox"/> Son <input type="checkbox"/> Stepson	<input type="checkbox"/> Daughter <input type="checkbox"/> Stepdaughter		
			<input type="checkbox"/> Son <input type="checkbox"/> Stepson	<input type="checkbox"/> Daughter <input type="checkbox"/> Stepdaughter		
			<input type="checkbox"/> Son <input type="checkbox"/> Stepson	<input type="checkbox"/> Daughter <input type="checkbox"/> Stepdaughter		
			<input type="checkbox"/> Grandson <input type="checkbox"/> Nephew	<input type="checkbox"/> Granddaughter <input type="checkbox"/> Niece		
			<input type="checkbox"/> Grandson <input type="checkbox"/> Nephew	<input type="checkbox"/> Granddaughter <input type="checkbox"/> Niece		

#### 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 SEIB's behalf.

\_\_\_\_\_

Employee 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 (including any probationary period during which the child is required to live with you),
  - c. your stepchild,
  - d. your grandchild, niece, or nephew for whom the court has granted custody to you or your spouse.

(Exception: children age 19 and older who are eligible for coverage through their employer are not eligible for coverage under SEHIP.)

3. 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 otherwise 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 wife, husband, or other dependents if they are independently covered as a State employee.

**STATE EMPLOYEES' INSURANCE BOARD**  
**POST OFFICE BOX 304900**  
**MONTGOMERY, ALABAMA 36130-4900**  
**334-263-8341 / 1-866-836-9737 FAX: 334-263-8541**

**RE-EMPLOYED STATE RETIREE ENROLLMENT FORM**

Use when a retiree is re-employed with a State agency





# State Employees' Health Insurance Plan

## 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 (including any probationary period during which the child is required to live with you),
  - c. your stepchild,
  - d. your grandchild, niece, or nephew for whom the court has granted custody to you or your spouse.

(Exception: children age 19 and older who are eligible for coverage through their employer are not eligible for coverage under SEHIP.)

3. 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 otherwise 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 wife, husband, or other dependents if they are independently covered as a State employee.

## **PLAN CHANGE FORM USES**

To change insurance companies during open enrollment

To enroll existing employees in Supplemental or Optional Coverage

To decline coverage on existing employees



# STATE EMPLOYEE PLAN CHANGE FORM

**SEHIP (Blue Cross)**  
Basic Medical

**\*Supplemental Coverage (Blue Cross)**  
Secondary Medical

**Optional Policies (Southland)**  
Vision Dental Cancer Hospital Indemnity

**Decline Coverage**

<b>SUBSCRIBER INFORMATION</b>					
Name (First, Middle Initial, Last)			Sex:	Effective Date of Coverage ____/____/____	
Contract #:			Date of Birth:		
Street Address:					
City		State		ZIP Code	
Home Telephone Number: (       )		Work Telephone Number: (       )		E-Mail Address:	
First Name	Middle Initial	Last Name	(Documentation is only required for enrollment in SEHIP) Relationship to Employee	Birth Date	Social Security Number
			<input type="checkbox"/> Husband <input type="checkbox"/> Wife		
			<input type="checkbox"/> Son <input type="checkbox"/> Stepson <input type="checkbox"/> Daughter <input type="checkbox"/> Stepdaughter		
			<input type="checkbox"/> Son <input type="checkbox"/> Stepson <input type="checkbox"/> Daughter <input type="checkbox"/> Stepdaughter		
			<input type="checkbox"/> Other Relationship		
<b>*IMPORTANT*</b> To be eligible for the non-tobacco and/or wellness discount, you must complete the Non-Tobacco User Discount Application form and meet the requirements of the Wellness Program.					
<b>PRIMARY GROUP HEALTH INSURANCE COVERAGE INFORMATION</b> (Must be completed if choosing supplemental coverage or Southland.)					
<b>Health Insurance Company</b>	<b>Contract Holder</b>	<b>Insurance Policy #</b>	<b>Group #</b>	<b>Name of Employer</b>	
Is Dental Coverage Available? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, you are required to complete the information below. If no, the State Employees' Health Insurance Plan Dental Coverage will serve as your primary dental coverage.			
<b>Dental Insurance Company</b>	<b>Contract Holder</b>	<b>Insurance Policy #</b>	<b>Group #</b>	<b>Name of Employer</b>	

## 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.

\_\_\_\_\_ Employee Signature

\_\_\_\_\_ Date

\* If choosing the Blue Cross Blue Shield (BCBS) Supplement coverage, you can not maintain your primary coverage through BCBS Group 13000 (State Employees' Health Insurance Plan), Group 30000 (Local Government Health Insurance Plan) or Group 14000 (Public Education Employees' Health Insurance Plan).

\*\* 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.

# State Employees' Health Insurance Plan

## 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 (including any probationary period during which the child is required to live with you),
  - c. your stepchild,
  - d. your grandchild, niece, or nephew for whom the court has granted custody to you or your spouse.

(Exception: children age 19 and older who are eligible for coverage through their employer are not eligible for coverage under SEHIP.)

3. 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 otherwise 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 wife, husband, or other dependents if they are independently covered as a State employee.

## **MEMBERSHIP STATUS CHANGE FORM USES**

To add dependent coverage

To drop dependent coverage

To cancel a dependent

To add a dependent to existing coverage

To change address

To cancel part-time employees

## **REVOKE ELECTION FORM USES**

Complete if canceling dependent coverage - (not applicable for retirees)





# State Employees' Health Insurance Plan

## 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 (including any probationary period during which the child is required to live with you),
  - c. your stepchild,
  - d. your grandchild, niece, or nephew for whom the court has granted custody to you or your spouse.

(Exception: children age 19 and older who are eligible for coverage through their employer are not eligible for coverage under SEHIP.)

3. 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 otherwise 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 wife, husband, or other dependents if they are independently covered as a State employee.

**STATE EMPLOYEES' INSURANCE BOARD**  
**POST OFFICE BOX 304900**  
**MONTGOMERY, ALABAMA 36130-4900**  
**334-263-8341 / 1-866-836-9737 / FAX: 334-263-8541**

**NOTICE: Complete ONLY if canceling dependent coverage. Not applicable for retirees.**

**REVOKE ELECTION FORM  
State Employees' Health Insurance Coverage**

Name: \_\_\_\_\_ Contract #: \_\_\_\_\_  
(Please Print)

Work Telephone: (\_\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ Agency: \_\_\_\_\_

I certify that I have incurred the following change in status:

- \_\_\_\_\_ Addition of dependent(s) through marriage, birth or adoption of a child, legal custody or placement for adoption;
- \_\_\_\_\_ Loss of dependent(s) through divorce, annulment, legal separation, death of a spouse or other dependent, or loss of legal custody;
- \_\_\_\_\_ Unpaid leave of absence for you or your spouse;
- \_\_\_\_\_ Termination or commencement of your spouse's or dependent's employment;
- \_\_\_\_\_ Change from full-time to part-time or part-time to full-time by the employee, spouse or dependent;
- \_\_\_\_\_ Change from hourly to salaried payroll status or vice versa;
- \_\_\_\_\_ Any other change in employment status not listed that results in the gain or loss of eligibility of the employee, spouse, or dependent;
- \_\_\_\_\_ Dependent's loss of coverage due to age;
- \_\_\_\_\_ Change of residence or worksite of employee, spouse or dependent;
- \_\_\_\_\_ Compliance with Issuance of family relations judgment, decree or order (i.e., QMCSO);
- \_\_\_\_\_ Medicare or Medicaid entitlement of employee, spouse or dependent;
- \_\_\_\_\_ Taking leave under the Family and Medical Leave Act;
- \_\_\_\_\_ To make changes in the IRC Section 401(k) and 401(m) elective and after-tax deferrals as permitted by those sections;
- \_\_\_\_\_ HIPAA Special Enrollment events;
- \_\_\_\_\_ Significant change in medical benefits or premiums.

Date qualifying event occurred \_\_\_\_\_ (Must be within the last 30 days.)

**Certification**

I understand that Federal regulations prohibit me from changing the election I have made after the beginning of the Plan Year, except under special circumstances. I understand that the change in my benefit election must be necessary or appropriate as a result of the status change under the regulations issued by the Department of the Treasury.

I hereby certify that the information furnished in this form is true and complete to the best of my knowledge.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Employee E-mail Address: \_\_\_\_\_

**STATE EMPLOYEES' INSURANCE BOARD  
POST OFFICE BOX 304900  
MONTGOMERY, ALABAMA 36130-4900  
334-263-8341 / 1-866-836-9737 / FAX: 334-263-8541**



## **OTHER FORMS**

### **REFUND REQUEST FORM USES**

Used to request refunds of premiums paid in error.

### **CREDIT BALANCE INVOICE FORM**

Use when Supplemental Health Insurance invoice is a credit.

Also used for prior-year refunds.

### **COBRA NOTICE MEMO USES**

Optional form that can be used if Personnel's Form 11 not used.

### **FPL APPLICATION**

Use to apply for FPL



SEIB OFFICE USE ONLY  
OK TO REFUND

Mo/Day/Year

By

**STATE EMPLOYEES' INSURANCE BOARD**  
POST OFFICE BOX 304900  
MONTGOMERY, ALABAMA 36130-4900  
334.263.8341 / FAX: 334.263.8541

### REFUND REQUEST

A refund of State Employees' Health Insurance premiums is requested for the department and/or employee referenced below:

**Agency Identification Data**

**Employee Identification Data**

Agency name \_\_\_\_\_

Employee name \_\_\_\_\_

Agency No. \_\_\_\_\_

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

(if applicable) Street Number

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Flex Plan: Yes \_\_\_\_\_ No \_\_\_\_\_

Social Security # \_\_\_\_\_

Refund amount \$ \_\_\_\_\_ Coverage Period: \_\_\_\_/\_\_\_\_/\_\_\_\_ through \_\_\_\_/\_\_\_\_/\_\_\_\_

Reason for requesting refund of premiums (check the appropriate line):

\_\_\_\_ Employee terminated: Date \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_ Employee retired: Date \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_ Employee began leave without pay: Date \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_ Employee notified SEIB on \_\_\_\_/\_\_\_\_/\_\_\_\_ to drop coverage on

\_\_\_\_ Employee \_\_\_\_ Dependent. Effective date \_\_\_\_/\_\_\_\_/\_\_\_\_ (Attach change form.)

\_\_\_\_ Dependent died: Date \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_ Employee died: Date \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_ Coverage was paid/deducted in error on \_\_\_\_ Employee \_\_\_\_ Dependent

for the period of \_\_\_\_/\_\_\_\_/\_\_\_\_ through \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_ Employee status changes to \_\_\_\_ full time \_\_\_\_ part-time: Date \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_ Other reason. Please explain \_\_\_\_\_

\_\_\_\_\_  
Signature of Official requesting refund



**STATE EMPLOYEES' INSURANCE BOARD**  
**CREDIT BALANCE INVOICE**

**Agency Name:** \_\_\_\_\_

**Agency #:** \_\_\_\_\_

**IFSH Invoice#:** \_\_\_\_\_

**Agency Credit Balance**  
**for the month of:**                    \_\_\_\_\_                    \_\_\_\_\_



# COBRA

Employer Notice Memo  
Or  
Send a copy of Form 11

\_\_\_\_\_  
Name of Employee

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Number and Street or P. O. Box

\_\_\_\_\_  
City State ZIP

The above identified employee of \_\_\_\_\_  
is covered in the SEHIP and under the provisions of COBRA we hereby provide SEIB notice that the  
following qualifying event has occurred relative to the employee.

1. \_\_\_\_\_ Termination of employment for any reason other than gross misconduct.  
Date of termination: \_\_\_\_\_
2. \_\_\_\_\_ Reduction in hours of employment. This includes leave without pay.  
Date of reduction: \_\_\_\_\_
3. \_\_\_\_\_ Death of the employee.  
Date of death: \_\_\_\_\_
4. \_\_\_\_\_ Medicare eligibility of the employee.  
Date of eligibility: \_\_\_\_\_

Date: \_\_\_\_\_ Employer: \_\_\_\_\_



## STATE EMPLOYEES' INSURANCE BOARD Federal Poverty Level (FPL) Discount Application

(Copies of your most recent income tax filing and pay stubs must be attached.)

### 1. Employee/Retiree Information

Name: First Middle Last		Contract Number of Employee:	
Address:			
City, State, Zip Code:			
Home Phone: (     )	Work Phone: (     )	Cell Phone: (     )	
Marital Status: (circle one)  Single            Married		E-mail Address:	

**2. Income:** List your household's current total monthly income. This includes **other** income sources listed below. **You must submit pay stubs or other necessary documentation verifying your current household income.**

1. Social Security (include Medicare premium)	12. Veterans Benefits, Pensions, Compensation or Insurance
2. SSI (Gold Check)	13. Insurance Annuity or Proceeds
3. Public Assistance (Welfare)	14. Government Payments on Land
4. Railroad Retirement	15. Coal, Oil, Gravel Rights, Timber Leases
5. Unemployment Compensation	16. Royalties
6. Legal Settlements	17. Child Support
7. Federal Civil Service Annuity	18. Interest on Savings
8. State Retirement/Pension	19. Private Pension
9. Miner's Benefits	20. Dividends
10. Black Lung Benefits	21. Other: Specify _____
11. Rental Income	

Name of Person Receiving the Payments	Source of Income	Current Gross Monthly Amount	Projected Annual Gross Amount

**NOTE:** You must submit your most current pay stub and most recent signed state and federal income tax returns. If you are married and you and your spouse file separately, you must submit your spouse's state and federal income tax returns as well. W-2 forms will not be accepted in place of pay stubs.

## FPL Application

### 3. Household Members

Line A - State Employee's/Retiree's name Line B - Spouse's name Line C -H names of dependents who live in your home	Social Security Number	Relationship to the State Employee	Date of Birth	Age	Sex
A.		SELF			
B.		SPOUSE			
C.					
D.					
E.					
F.					
G.					
H.					

**4. Affirmation:** I declare that the above statements and answers are true, complete and correctly recorded.

I understand that submitting false or misleading information on this application is a crime punishable under state and federal law. I also recognize and understand that if any of the statements or answers recorded are found to be incorrect, incomplete, false or misleading, I will also be subject to disciplinary action, including termination of employment, and will be required to repay all discounts, plus interest.

\_\_\_\_\_  
**Signature of Employee/Retiree**

\_\_\_\_\_  
**Date**

Please return to: State Employees' Insurance Board  
Attention: Accounting  
P.O. Box 304900  
Montgomery, AL 36130  
Phone: 334-263-8379  
Fax: 334-263-8720