ADMINISTRATIVE PROCEDURES GUIDE

State Employees' Insurance Board

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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.

CONTENTS

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 employee covered under the SEHIP who carried family coverage, the eligible dependents may continue coverage by making the appropriate premium payments to the SEIB. Pursuant to Act 2012-498, the spouse and dependents of an employee covered under the SEHIP who is killed in the line of duty or who dies as a result of injuries received in the line of duty may continue coverage under the SEHIP with the cost of continued coverage to be paid by the State Treasury. (Coverage shall cease upon remarriage or upon the attainment of an alternate health insurance provider.) SEIB must be notified within 90 days of the date of 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.

Changes in Dependent Eligibility
It is the responsibility of the subscriber to notify the SEIB immediately when the eligibility of a covered dependent changes. If it is determined that an act (such as adding an ineligible person to coverage) or omission (such as failing to remove a person no longer eligible from coverage) of the subscriber results in or contributes to the payment of claims by the SEHIP for persons ineligible for coverage, the subscriber will be personally responsible for all such overpayments and shall be subject to disciplinary action including termination of coverage. (Note: an ex-spouse is ineligible for coverage and cannot be maintained as a dependent under family coverage regardless of a judgment or divorce decree requiring the subscriber to provide health care of an ex-spouse. However, an ex-spouse may be eligible for COBRA continuation coverage.)

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 1st and 15th, the full individual premium will be deducted from the employee's first paycheck. If date of hire is between the 16th and 31st, 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 coverage only during the open enrollment period in November each year. Exception: dependents gained through birth, adoption or marriage may be added to coverage during the plan year if a change form is submitted 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 a payroll check or the deposit by the SEIB of a 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 3/4 time	50%	50% + employee premium
At least 3/4 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 a 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 1st 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.

A request for Special Enrollment must include:

1. a letter requesting special enrollment submitted to the SEIB within 30 days of the qualifying event, along with a completed enrollment form or status change form if only adding dependents.
2. thereafter, the following documentation must be submitted within 60 days of the qualifying event:
   a. proof of gaining a new dependent (e.g. marriage certificate, birth certificate, adoption papers, etc.)
   b. proof of coverage loss listing the reason and the date of the coverage loss for all individuals affected (e.g. employment termination on company letterhead),
   c. a Certificate of Creditable Coverage from the health insurer with the coverage information that includes coverage period and end date.

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.

J. Address Changes

All correspondence and notices required under the provisions of the SEHIP or state or federal law will be delivered to the address provided by you in our records. It is your responsibility to ensure that your address of record is accurate. To change an address, a written request may be submitted to the SEIB office at PO Box 304900, Montgomery, Alabama 36130-4900 or by visiting our web page at www.alseib.org**.** An address cannot be updated by Blue Cross and Blue Shield of Alabama or made from information shown on claim forms.

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., 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.

A request for Special Enrollment must include:

1. a letter requesting special enrollment submitted to the SEIB within 30 days of the qualifying event, along with a completed enrollment form or status change form if only adding dependents.
2. thereafter, the following documentation must be submitted within 60 days of the qualifying event:
   a. proof of gaining a new dependent (e.g. marriage certificate, birth certificate, adoption papers, etc.)
   b. proof of coverage loss listing the reason and the date of the coverage loss for all individuals affected (e.g. employment termination on company letterhead),
   c. a Certificate of Creditable Coverage from the health insurer with the coverage information that includes coverage period and end date.

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) has 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
Eligibility – All active employees covered under the State Employees' Health Insurance Plan (Group 13000) are eligible for a wellness premium discount. Each wellness plan year is December 1 through November 30 and every active employee must be screened either through the SEIB's worksite wellness screening program or by a healthcare provider (through the submission of a Provider Screening Form).

Risk Factors - are blood pressure, total cholesterol, glucose, and body mass index. You are considered to be "at risk" if your:

a. Blood pressure systolic reading is 160 or higher, or your diastolic reading is 100 or above;
b. Cholesterol reading is equal to or above 250;
c. Glucose reading is equal to or above 200;
d. Body mass index is equal to or above 35.

Screening Referral – Employees who participate in the worksite wellness screening and are discovered to have any of these risk factors may be eligible for an office visit referral copay waiver. The office visit copay waiver is only for members covered under Group 13000 and only waives the office visit copay. You are responsible for all other applicable copays, such as lab test copays.

Managing Your Screening Results – You can earn the wellness premium discount within the wellness plan year in the following ways:

a. Submission of health screening results through a worksite wellness program indicating that you <u>are not</u> at risk for one or more of the above health risk indicators; or
b. Submission of a <u>completed and signed</u> office referral form indicating that you have been counseled by a healthcare provider for your identified risk(s) indicators; or
c. Submission of participation in a YMCA, Gold's Gym, Curves or other SEIB approved program(s). You must provide documentation of your participation.
d. Provide valid proof that you are self-managing and have <u>made improvement</u> in your identified risk(s). You must provide documentation of your improvement; or
e. Submission of a completed Provider Screening Form.

Exceptions – 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 of 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 meet the criteria 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.

For More Information - Call 1.866.838.3059 or visit **www.alseib.org**.

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.

WELLNESSS 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.

IB02

HEALTH INSURANCE ENROLLMENT FORM

08/12

☐ **SEHIP** (Blue Cross) Basic Medical

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

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

☐ **Decline Coverage**

SUBSCRIBER INFORMATION

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

Dependent Coverage is requested for the following individuals, effective on Month _____Day _____ Year_____. Direct payment MUST be made for any premiums that will not be payroll deducted. Make check payable to the SEIB and attach to this form.

First Name Middle Initial Last Name	Documentation is required. Relationship to Employee	Date of Birth	Social Security Number
	☐ Husband ☐ Wife		
	☐ Son ☐ Stepson ☐ Daughter ☐ Stepdaughter		
	☐ Son ☐ Stepson ☐ Daughter ☐ Stepdaughter		
	☐ Other Relationship		

IMPORTANT To be eligible for the non-tobacco and/or wellness discount, you must complete the Non-Tobacco User Discount Application and meet the requirements of the Wellness Program.

ADDITIONAL GROUP HEALTH INSURANCE COVERAGE INFORMATION
(Must be completed if choosing supplemental coverage or Southland.)

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

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

Is Dental Coverage Available? Yes 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.

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

TO BE COMPLETED BY EMPLOYER

1. EMPLOYMENT STATUS:

_____Full Time _____3/4 Time _____½ Time _____1/4 Time

2. EMPLOYEE'S EFFECTIVE DATE OF COVERAGE: _____

3. PAY FREQUENCY: _____ Semi-Monthly Arrears

_____ Semi-Monthly Current _____ Monthly

_____
Signature of Payroll Clerk Date

_____
State Agency

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

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
P.O. BOX 304900
MONTGOMERY, AL 36130
PHONE: 334.263.8341 / 1.866.836.9737 / FAX: 334.517.9728

STATE EMPLOYEES' INSURANCE BOARD
NON-TOBACCO USER DISCOUNT APPLICATION

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

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: _____ **Date:** _____
Contract Holder

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: _____ **Date:** _____
Contract Holder

Signed: _____ **Date:** _____
Spouse (if covered under SEHIP)

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: 334.517.9728

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. NOTE: Incomplete forms will not be processed. Refunds are not allowed.

SECTION 1 (To Be Completed by Employee)

Member Name (Please print)	Screening Date	Male ☐ Female ☐	Age: _____

Contract Number	Social Security Number	Date of Birth	Day Time Phone Number

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)

Blood Pressure _____ **/** _____	
Total Cholesterol_____ **mg/dL**	**Height** _____**ft.** _____ **in**
HDL Cholesterol _____ **mg/dL**	**Weight** _____
LDL Cholesterol _____ **mg/dL**	**BMI** _____
Triglycerides _____ **mg/dL**	**Waist Measurement**_____ **in**
Blood Glucose _____ **mg/dl**	**Waist/HT Ratio**_____

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: 334.517.9980

IB07

State Employees' Insurance Board

12/2012

State Employees' Health Insurance Plan

Wellness Discount Certification Form

Member Name (Please print)		Male ☐ Female ☐	Age: _____
Contract Number	**Social Security #**	**Date of Birth**	**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 a Physician Supervised Weight Management program.

Name and Phone number of program_____

Date(s) I attended _____

☐ I participated in a participating SEIB Fitness Center wellness program (i.e., YMCA, Curves)

Name and Phone number 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: 334.517.9980

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

STATE EMPLOYEES' INSURANCE BOARD
POST OFFICE BOX 304900
MONTGOMERY, ALABAMA 36130-4900
334.263.8341 / 1.866.836.9737 / Fax: 334.517.9728

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 1st day of the month)
Social Security Number		Date of Birth	☐ Vision (Monthly premium $24)
Mailing Address			**A minimum enrollment of 12 months required for employees/ dependents**
City	State	ZIP Code	☐ Single Coverage
Home Telephone Number	Work Telephone Number		☐ Family Coverage **(List dependents below.)**
			☐ Cancel Coverage
E-mail Address:			

First Name Initial Last Name	(Documentation is Required) Relationship to Employee		Date of Birth	Social Security Number
	☐ Husband	☐ Wife		
	☐ Son ☐ Stepson	☐ Daughter ☐ Stepdaughter		
	☐ Son ☐ Stepson	☐ Daughter ☐ Stepdaughter		
	☐ Son ☐ Stepson	☐ Daughter ☐ Stepdaughter		
	☐ Son ☐ Stepson	☐ Daughter ☐ Stepdaughter		
	☐ Grandson ☐ Nephew	☐ Granddaughter ☐ Niece		
	☐ Grandson ☐ Nephew	☐ Granddaughter ☐ 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: 334.517.9728

RE-EMPLOYED STATE RETIREE ENROLLMENT FORM

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

RE-EMPLOYED STATE RETIREE HEALTH INSURANCE FORM

☐ **SEHIP (BCBS)**
Re-employed Retiree Coverage

☐ **Decline Coverage**

SUBSCRIBER INFORMATION		
Name (First, Middle Initial, Last):		Sex:
Social Security Number:	Date of Birth:	Medicare Number (if applicable)
Street Address:		
City:	State:	ZIP Code:
Home Telephone Number:	Work Telephone Number:	E-Mail Address:

List covered dependents below.

First Name Middle Initial Last Name	Relationship to Employee	Birth Date	Social Security Number
	☐ Husband ☐ Wife		
	☐ Son ☐ Stepson ☐ Daughter ☐ Stepdaughter		
	☐ Son ☐ Stepson ☐ Daughter ☐ Stepdaughter		
	☐ Other Relationship		

IMPORTANT: To be eligible for the non-tobacco discount, you must submit a Non-Tobacco User Discount Application form if you do not have one on file.
Remember: If you or your dependents have Medicare, upon returning to work, Medicare becomes secondary to the SEHIP.

TO BE COMPLETED BY EMPLOYER

DATE STARTED TO WORK: _____

_____
Signature of Payroll Clerk Date

_____
State Agency

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

Return to: State Employees' Insurance Board
Post Office Box 304900
Montgomery, Alabama 36130-4900
334-263-8341 / 1-866-836-9737 / Fax: 334.517.9728

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

IB14

STATE EMPLOYEE PLAN CHANGE FORM

10/2012

☐ **SEHIP** (Blue Cross) Basic Medical

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

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

☐ **Decline Coverage**

SUBSCRIBER INFORMATION				
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
	☐ Husband ☐ Wife		
	☐ Son ☐ Stepson ☐ Daughter ☐ Stepdaughter		
	☐ Son ☐ Stepson ☐ Daughter ☐ Stepdaughter		
	☐ Other Relationship		

IMPORTANT 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.

PRIMARY GROUP HEALTH INSURANCE COVERAGE INFORMATION

(Must be completed if choosing supplemental coverage or Southland.)

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

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

Is Dental Coverage Available? ☐ **Yes** ☐ **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.**

Dental Insurance Company	**Contract Holder**	**Insurance Policy #**	**Group #**	**Name of Employer**

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.

State Employees' Insurance Board
Post Office Box 304900
Montgomery, Alabama 36130-4900
334-263-8341 / 1-866-836-9737 / Fax: 334.517.9728

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 EMPLOYEE'S MEMBERSHIP STATUS CHANGE

SUBSCRIBER INFO Name (First, Middle Initial, Last)	CONTRACT NUMBER:	EFFECTIVE DATE OF CHANGE: _____ Month/Day/Year

☐ Cancel Subscriber's coverage (part-time employees only) Date became part-time: _____

DROP DEPENDENT COVERAGE **Please check appropriate box.**		**ADDITIONS – PROVIDE DOCUMENTATION** (270-day waiting period for pre-existing conditions) **Please check appropriate box.**	
	Change from Family to Single Coverage		Change from Single to Family Coverage – Add Dependent(s)
	Cancel dependent(s) listed below from Family Coverage		Add dependent(s) listed below to Family Coverage
Reason for Cancellation:			Adding Former State Employee
	Death (give date):	Former Employee's Social Security #	
	Divorce - attach final divorce decree (required)	Last work day:	
	Other (explain/give date)		

First Name Middle Initial Last Name	**Documentation is required. Relationship to Employee**		**Date of Birth**	**Social Security Number**
	☐ **Husband**	☐ **Wife**		
	☐ **Son** ☐ **Stepson**	☐ **Daughter** ☐ **Stepdaughter**		
	☐ **Son** ☐ **Stepson**	☐ **Daughter** ☐ **Stepdaughter**		
	☐ **Son** ☐ **Stepson**	☐ **Daughter** ☐ **Stepdaughter**		
	☐ **Other Relationship**			

IMPORTANT If you are currently receiving a non-tobacco user premium discount, the discount will be discontinued when you add a spouse to coverage unless a new premium discount form is submitted to the SEIB. Contact your insurance clerk or the SEIB about how to apply.

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

State Agency:_____

☐ Change Address To:

_____
Street Address Apartment Number

_____
City County State ZIP

(_____)_____ Ext._____
Work Telephone

(_____)_____
Home Telephone

_____
Employee E-Mail Address

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.)

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   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.

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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:

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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: 334.517.9728

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: _____ 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: 334.517.9728

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

IB10
Revised 09/12

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: 334.517.9728

REFUND REQUEST

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

Agency Identification Data

Agency name_____

Agency No. _____

Flex Plan: Yes_____ No_____

Employee Identification Data

Employee name_____

Address _____

City _____State____ ZIP_____

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: _____ _____

Return to:

State Employees' Insurance Board
Post Office Box 304900
Montgomery, Alabama 36430-4900
Attention: Sandra George

C O B R A

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
POST OFFICE BOX 304900
MONTGOMERY, ALABAMA 36130-4900
334.263.8341 / 1.866.836.9737 / 334.517.9728

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: 334.517.9741