ADMINISTRATIVE PROCEDURES GUIDE

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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. ELIGIBILITY & ENROLLMENT

A. Eligible Employee

The term "employee" includes only:

- 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.

- Part-time employees working at least ten hours per week are only eligible for the Basic Medical Health Insurance Plan if they agree to have the required premium paid through payroll deduction.

- 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.):

- Your spouse (excludes divorced or common-law spouse)

- A child under age 26, only if the child is:
  - your son or daughter,
  - a child legally adopted by you or your spouse (including any probationary period during which the child is required to live with you),
  - your stepchild,
  - your grandchild, niece, or nephew for whom the court has granted custody to you or your spouse.

- An incapacitated dependent over age 25 will be considered for coverage provided dependent:
  - is unmarried,
  - is permanently mentally or physically disabled or incapacitated,
  - is so incapacitated as to be incapable of self-sustaining employment,
  - is dependent on you for 50% or more support,
  - is otherwise eligible for coverage as a dependent except for age,
  - the condition must have occurred prior to the dependent's 26th birthday, and
  - 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:

- When a new employee requests coverage for an incapacitated dependent within 60 days of employment; or

- When an employee's incapacitated dependent is covered under a spouse's employer group health insurance for at least 18 consecutive months and:
  - 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,
  - a change form is submitted to the SEIB within 30 days of the incapacitated dependent's loss of other coverage, and
  - 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.)

Qualified Medical Child Support Orders
If the SEIB receives an order from a court or administrative agency directing the SEHIP to cover a child, the SEIB will determine whether the order is a Qualified Medical Child Support Order (QMCSO). A QMCSO is a qualified order from a court or administrative agency directing the plan to cover the employee's child regardless of whether the employee has enrolled the child for coverage. The SEIB has adopted procedures for determining whether such an order is a QMCSO. You have a right to obtain a copy of those procedures free of charge by contacting your SEIB.

The SEHIP will cover an employee's child if required to do so by a QMCSO. If the SEIB determines that an order is a QMCSO, the child will be enrolled for coverage effective as of a date specified by the SEIB, but not earlier than the later of the following:

- If the SEIB receives a copy of the order within 30 days of the date on which it was entered, coverage will begin as of the date on which the order was entered.

- If the SEIB receives a copy of the order later than 30 days after the date on which it was entered, coverage will begin as of the date on which the SEIB received the order. The SEIB will not provide retroactive coverage in this instance.

Coverage may continue for the period specified in the order up to the time the child ceases to satisfy the definition of an eligible dependent. If the employee is required to pay extra to cover the child, the SEIB may increase the employee's payroll deductions. During the period the child is covered under the SEHIP as a result of a QMCSO, all SEHIP provisions and limits remain in effect with respect to the child's coverage except as otherwise required by federal law.

While the QMCSO is in effect the SEHIP will make benefit payments – other than payments to providers – to the parent or legal guardian who has been awarded custody of the child. The SEIB will also provide sufficient information and forms to the child's custodial parent or legal guardian to allow the child to enroll in the SEHIP. The SEIB will also send claims reports directly to the child's custodial parent or legal guardian.

C. Enrollment, Commencement and Reporting

Upon enrollment coverage commences as stated below:

- **Employee**
  - new employees who do not decline coverage will be enrolled as of the **effective date of employment**, subject to SEIB rules and procedures.
  - an SEIB Health Insurance Enrollment Form must be completed by the employee and his/her employer and submitted to the SEIB.
  - the SEIB will bill the employer a pro rata premium for every new employee for the month in which his/her coverage begins.
  - 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.
  - 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.

- **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.

  - 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.
  - New employees may elect to have dependent coverage begin on the date of their employment or no later than the first day of the second month following their hire date, subject to appropriate premium payments.
  - Thereafter, 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.)
  - 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.

- **Part-time Employees**
  - Eligibility
    - 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. Part time employees must be enrolled in the Basic Medical Health Insurance Plan in order to enroll in dental or vision coverage.

    - 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.

    - 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

  - Determination of Status
    - 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.
      - such reviews will consider the rate of pay and hours worked in determining the employment status of any part-time employee;
      - employers will be advised on any status questioned by the SEIB and will be required to revise or certify the status reported.
    - The employment status in effect on the first day of the month shall apply throughout that month for insurance purposes.
    - 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.
    - Changes in employment status should be reported to the SEIB on a Form 11 or with a memo.

  - Termination of Coverage

    Individuals whose employment status changes from full-time to part-time will not automatically be payroll coded for <u>**no**</u> 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.

  - Enrollment
    - 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.

- 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. Transfers

- 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.

- 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.

E. Open Enrollment

- Annual open enrollment shall be held in November of each year for coverage to be effective January 1.

- 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.

F. 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:

- the employee declined to enroll in the SEHIP because of other employer group coverage and submitted a completed "Declination of Coverage"; and
- the employee gains a new dependent through marriage, birth or adoption; or
- the employee or dependent loses the other employer group coverage because:
  - COBRA coverage (if elected) is exhausted, or
  - loss of eligibility (including separation, divorce, death, termination of employment or reduction of hours of employment), or
  - employer stopped contribution to coverage; and,
  - 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:

- 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.
- thereafter, the following documentation must be submitted within 60 days of the qualifying event:
  - proof of gaining a new dependent (e.g. marriage certificate, birth certificate, adoption papers, etc.)
  - 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),

G. 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 is primary for services covered by Medicare.

H. 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.

I. 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.

J. 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:

- 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.

- when this plan is discontinued.

Coverage under this plan will also terminate for a dependent:

- on first day of the following month in which such person ceased to be an eligible dependent.
- if the dependent becomes covered as an employee.
- 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:

- 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.

  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.

- 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)

- **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.

- **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.

- **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).

- **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.

- **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

In order for an employee to receive a refund for premiums paid to the SEIB in error, the agency must complete SEIB Form IB10 and forward it to the SEIB. (A copy of the Refund Request form can be found in this administrative guide and on the SEIB website at alseib.org/healthinsurance/sehip/forms.aspx).

Effective September 1, 2013, SEIB employer supplemental billings and credits for agency employees will be transmitted electronically directly to the State Comptroller's Office for upload and processing in payroll cycles. A billing statement will be available for download via the SEIB website to the agency's **authorized** payroll/personnel officers. The state share will be charged to the payroll fund designated in GHRS for the employee based on accounting codes in GHRS. The charge will be reflected on the agency's fringe benefit payroll journal voucher in CAS each payroll cycle. The charges will also be reflected on the GHRS HAR020G General Ledger Detail Report available on the Comptroller's website to **authorized** departmental personnel each pay cycle.

Effective October 1, 2013, all employee premium refunds will be credited back to the employee in their pay check through the GHRS payroll system. A refund of pretax premiums will be subject to Federal, State, FICA and/or Medicare taxes.

If you have questions regarding the changes to the SEIB supplemental billings or refunds, please contact SEIB staff at **www.alseib.org** and/or at 334.263.8374 or toll-free at 866.836.9737. For questions regarding the payroll charge out, please call the GHRS Hotline at 334.242.2188.

III. RETIREE ELIGIBILITY & ENROLLMENT

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

- 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.
- 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.
- 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.

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. 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:

- the retired employee declined to enroll in the SEHIP because of other coverage and submitted a completed "Declination of Coverage;" and
- the retiree gains a new dependent through marriage, birth or adoption; or
- the retiree or dependent loses the other employer group coverage because:
  - COBRA coverage (if elected) is exhausted, or
  - loss of eligibility (including separation, divorce, death, termination of employment or reduction of hours of employment), or
  - employer stopped contribution to coverage; and,
- 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:

- 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.
- thereafter, the following documentation must be submitted within 60 days of the qualifying event:
  - proof of gaining a new dependent (e.g. marriage certificate, birth certificate, adoption papers, etc.)
  - 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),

G. 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:

- does not voluntarily terminate participation in the DROP within the first three years and
- 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.

H Retiree Other Employer 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 or optional coverage.

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

I. 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. Less than ¼ time employees and professional services contract employees are exempt.

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.

IV. EMPLOYEE COVERAGE OPTIONS TO SEHIP

A. Optional Plans

- 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.
- 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.

NOTE: High deductible plans with single deductible of $1250 or more and family deductible of $2500 or more are not allowed to enroll in the supplemental coverage plan. A summary plan description of the other coverage must be provided to document the deductible amount.

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.

- 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, dental or vision plan.

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

- SEPOP/HRA

  The SEPOP is a premium only Health Reimbursement Arrangement (HRA) funded solely by the State of Alabama from which active employees are reimbursed for other employer group health insurance premiums.

  Any active full-time employee of the State of Alabama eligible for coverage under the State Employees' Health Insurance Plan (SEHIP) who has opted out of the SEHIP is eligible to enroll in the SEPOP.

  Enrollment in the SEPOP will establish an account into which the State will credit $150 each month. Tax free benefit dollars can be used to pay premiums for other-employer group health insurance (e.g. coverage offered through your spouse's employer).

  Employees can enroll in the SEPOP at any time during the year by completing Form IB26.

  Employees can dis-enroll in the SEPOP and re-enroll in the SEHIP at any time during the year. When an employee dis-enrolls in the SEPOP or terminates employment, any Benefit Dollars in their SEPOP Account will revert back to the Plan.

- Dental Coverage
  Beginning January 1, 2014, dental coverage will be offered as a separate benefit with a monthly premium for single and for family coverage. The Blue Cross Dental Plan and the Southland Dental Plan are available. Enrollment applications are accepted for date of hire, open enrollment or special

enrollment. Dependent documentation is required. A minimum enrollment of 12 months required for employees and dependents. Employees can either enroll in conjunction with SEHIP, Supplemental, SEPOP or Vision Plans or in a dental-only plan.

- Vision Coverage
  Southland Vision coverage is available with a monthly premium. Enrollment applications are accepted for date of hire, open enrollment or special enrollment. A minimum enrollment of 12 months is required for employees and dependents. Employees can either enroll is conjunction with SEHIP, Supplemental, SEPOP or either dental plan or in a vision-only plan.

B. Optional Discounts

- Federal Poverty Level Discount Program (Form IB12)
  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, or part-time employees' premiums. Dental and vision coverage premiums are not discounted.

  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.

- 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.

- Wellness Premium Discount
  - Eligibility - All active employees covered under the State Employees' Health Insurance Plan (Group 13000) are eligible for a wellness premium discount. The wellness qualifying period is October 1, 2013 through October 31, 2014, for a January 1, 2015 effective date. Every active employee must be screened either through the SEIB's worksite wellness screening program, a county health department, a participating pharmacist, or by a healthcare provider (through the submission of a Provider Screening Form).

  Effective for the 2015 plan year, covered spouses of active employees, non-Medicare retirees and non-Medicare covered spouses of retirees are eligible for a wellness premium discount. In order to receive the wellness discount in 2015 and thereafter, every covered spouse of an active employee, non-Medicare retiree and non-Medicare covered spouse of a retiree must be screened either through the SEIB's worksite wellness screening program, a county health department, a participating pharmacist, or by a healthcare provider (through the submission of a Provider Screening Form). The qualifying period is October 1, 2013 thru October 31, 2014 for a January 1, 2015 effective date.

  - Risk Factors – are blood pressure, total cholesterol, glucose, and body mass index. You are considered to be "at risk" if your:
    - Blood pressure systolic reading is 160 or higher, or your diastolic reading is 100 or above;
    - Cholesterol reading is equal to or above 250;
    - Glucose reading is equal to or above 200;
    - Body mass index is equal to or above 40

  - Screening Referral – Participants screened at the worksite, county health department, or pharmacies that are discovered to have one or more of these risk factors may be eligible for an office visit copay waiver referral. 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. **This copay waiver is not applicable at an emergency room or urgent care center.**

  - Managing Your Screening Results – You can earn the wellness premium discount within the wellness plan year in the following ways:
    - Submission of health screening results through an SEIB wellness program indicating that you are not at risk for one or more of the above health risk indicators; or
    - Submission of a completed and signed office referral form indicating that you have been counseled by a healthcare provider for your identified risk(s) indicators; or
    - Submission of participation in a YMCA, Gold's Gym, Curves or other SEIB approved program(s). You must provide documentation of your participation.
    - Provide valid proof that you are self-managing and have made improvement in your identified risk(s). You must provide documentation of your improvement; or
    - Submission of a completed Provider Screening Form.

Exceptions – An eligible individual may also receive the wellness premium discount if it is deemed that the eligible individual cannot participate in the wellness program due to pregnancy, disability of other infirmity as documented by the eligible individual'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 October 31 of the preceding year. New employees will have 60 days from date of

hire to apply for the wellness premium discount. Covered spouses of active employees, non-Medicare retirees and non-Medicare covered spouses of retirees will have 60 days from their effective date to apply for the wellness premium discount.

For more information call 1.866.838.3059 or visit **www.alseib.org**.

- Spousal Surcharge Waiver
  Effective January 1, 2014, if a spouse is enrolled in the SEHIP, they will be subject to a $50 surcharge per month. In order to apply for a waiver for the spousal surcharge, Form IB-25 must be submitted with the required documentation. New Employees will have 60 days from date of hire to apply for the waiver. When a new spouse is added, the 60 day period will also apply.

ENROLLMENT FORM IB02 USES

To enroll new employees
To re-enroll employees returning from LWOP
To decline coverage for new employees

SEPOP/HRA FORM IB26

Attach this form with IB02 when enrolling in SEPOP

ACTIVE/RETIRED DENTAL INSURANCE ENROLLMENT/CANCELLATION FORM IB21

Attach this form with IB02 when adding dental coverage
To enroll/cancel dental coverage during Open Enrollment

SOUTHLAND VISION ENROLLMENT/CANCELLATION FORM IB20

Attach this form with IB02 when adding vision coverage
To enroll/cancel vision coverage during Open Enrollment

SALARY REDUCTION AGREEMENT

Use for new employees to opt out of premium conversion plan.
Also use for employees to enroll and opt out for open enrollment only.

IB02 **ACTIVE EMPLOYEE HEALTH INSURANCE ENROLLMENT FORM** Revised 4/14

SELECT ONLY ONE

- ☐ **SEHIP Medical***
  To add dental attach Form IB21
  To add vision attach Form IB20
- ☐ **BCBS Supplemental Coverage**
  To add dental attach Form IB21
  To add vision attach Form IB20
- ☐ **SEPOP/HRA**
  Must attach Form IB26
  To add dental attach Form IB21
  To add vision attach Form IB20
- ☐ **Southland Optional Policies**
  Vision / Dental / Cancer / Hospital Indemnity
- ☐ **Southland – Dental Only**
- ☐ **Southland – Vision Only**
- ☐ **Blue Cross – Dental Only**
- ☐ **Vision & Dental Coverage Only**
  Attach Forms IB20 and IB21
- ☐ **Decline All Coverage**

SUBSCRIBER INFORMATION

Name (First, Middle Initial, Last)	Sex	Social Security #	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 for SEHIP and dental plans. Relationship to Employee	Date of Birth	Social Security Number
	☐ Husband* ☐ Wife*		
	☐ Son ☐ Stepson ☐ Daughter ☐ Stepdaughter		
	☐ Son ☐ Stepson ☐ Daughter ☐ Stepdaughter		
	☐ Grandson ☐ Granddaughter ☐ Nephew ☐ Niece		

***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. When adding a spouse to SEHIP coverage, a spousal surcharge of $50 per month will be applied. To receive a discount you must submit a Spousal Surcharge Waiver Application (IB25). Forms are available at www.alseib.org

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

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

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

NOTE: High deductible plans with single deductible of $1250 or more and family deductible of $2500 or more are not allowed to enroll in the supplemental coverage plan. A summary plan description of the other coverage must be provided to document the deductible amount. In addition please note the State Employees' Supplemental Coverage Plan does not coordinate with the SEIB HRA (State Employees' Premium Only Plan).

If choosing the Blue Cross Blue Shield (BCBS) Supplement coverage, you cannot 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.

TO BE COMPLETED BY EMPLOYER

1. EMPLOYMENT STATUS:

   ______Full Time _____3/4 Time _____1/2 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 State Agency Date

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.

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 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 Premium Only Plan Enrollment Form

Return completed form to: State Employees' Insurance Board, PO Box 304900, Montgomery AL 36130-4900
Telephone: 334.263.8312 Toll Free: 1.866.833.3378 Fax: 334.517.9908

EMPLOYEE INFORMATION (PLEASE PRINT)		
Name:	**SEHIP Contract or SSN #**	**Date of Birth ______/______/_______**
Address:		
City, State and Zip:		
Telephone Numbers (<u>work number is required</u>) Work: ( ) Ext:	**Home: ( )**	
Email Address:		
Name of health plan for which you will be seeking reimbursement of premiums:		
Employer Name:	**Group Number:**	**Contact number: ( )**

What is the State Employees' Premium Only Plan (SEPOP)?
The SEPOP is a premium only Health Reimbursement Arrangement (HRA) funded solely by the State of Alabama from which active employees are reimbursed for other employer group health insurance premiums.

Who is eligible?
Any active full-time employee of the State of Alabama eligible for coverage under the State Employees' Health Insurance Plan (SEHIP) who has opted out of the SEHIP is eligible to enroll in the SEPOP.

What's the benefit to enrolling in the SEPOP?
When you enroll in the SEPOP an account will be established for you into which the State will credit $150 each month. You can then use these tax free Benefit Dollars to pay premiums for other employer group health insurance (e.g. coverage offered through your spouse's employer). That's a free benefit of up to $1,800 per year.

Can SEPOP Benefit Dollars be used for any health care premium?
No. SEPOP Benefit Dollars can only be applied toward premiums of other employer group health plans meeting the minimum value and essential health benefits criteria as defined under the Affordable Care Act (employers should provide their employees with this information).

Will Benefit Dollars in your SEPOP account roll over each year?
Yes. If you don't spend all your Benefit Dollars in a Plan Year, any unused SEPOP Account balance rolls over into the next Plan Year. In this manner your SEPOP Account may "grow" almost like a savings account.

How do you enroll?
You can enroll in the SEPOP at any time during the year by completing this form and returning it to the SEIB. Remember you must first opt out of the SEHIP before you can enroll in the SEPOP.

How do you dis-enroll?
You can dis-enroll in the SEPOP and re-enroll in the SEHIP at any time during the year. When you dis-enroll in the SEPOP or terminate your employment, any Benefit Dollars in your SEPOP Account will revert back to the Plan.

Important – Read Carefully Before Signing

The SEPOP is intended to qualify as a "health reimbursement arrangement" as that term is defined under IRS Notice 2002-45 and 2013-54 and a medical reimbursement plan under Sections 105 and 106 of the Internal Revenue Code of 1986, as amended, and the Plan will be interpreted at all times in a manner consistent with such intent. I understand that I will only seek reimbursement for premiums for health insurance coverage that qualify for such reimbursement under IRS regulations. I hereby certify that I have completely read and fully understand the terms and conditions of the SEPOP and all information furnished is true and complete.

Employee Signature: ____ Date: ______________________________

State Employees' Insurance Board Active/Retired Dental Insurance Enrollment/Cancellation Form

SUBSCRIBER INFORMATION

Name (First, Middle Initial, Last)		Sex	Effective Date
Social Security Number		Date of Birth	☐ Blue Cross Dental ☐ Southland Dental
Mailing Address			**A minimum enrollment of 12 months required for employees/ dependents**
City	State	ZIP Code	☐ Single Coverage - $3/monthly
Home Telephone Number	Work Telephone Number		☐ Family Coverage - $8/monthly **(List dependents below.) (Documentation is Required)** ☐ 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.

______________________________ 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.

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.

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' 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) **A minimum enrollment of 12 months required for employees/ dependents** ☐ Single Coverage ☐ Family Coverage **(List dependents below.)** ☐ Cancel Coverage
Mailing Address			
City	State	ZIP Code	
Home Telephone Number	Work Telephone Number		
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.

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

New Employee – Open Enrollment

Salary Reduction Agreement
Premium Conversion Plan

This form allows you to enroll and/or opt out of the 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 Premium Conversion Plan. I authorize the State to redirect a part of my salary to pay premiums with pretax dollars.
( ) I do not elect to enroll in the 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

PREMIUM DISCOUNT APPLICATIONS

Use these forms to receive discounts on premiums

Non-Tobacco User Discount Application Form IB05

Annual Tobacco User Premium Discount Application Form IB06

Wellness Certification Form IB07

Provider Screening Form IB13

Spousal Surcharge Waiver Form IB25

Federal Poverty Level Discount Application IB12

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' HEALTH INSURANCE PLAN
ANNUAL TOBACCO USER PREMIUM DISCOUNT APPLICATION

Name of Contract Holder	Contract Number

Declaration

Check the appropriate box below:

☐ I have used tobacco products within the last 12 months.

☐ My spouse has used tobacco products within the last 12 months and is covered as a dependent under the SEHIP.

☐ I have completed an SEIB approved tobacco cessation program (verification attached).

☐ My spouse has completed an SEIB approved tobacco cessation program (verification attached).

☐ I cannot stop using tobacco products as advised by my physician because it is unreasonably difficult due to a medical condition (statement from physician attached).

☐ My spouse cannot stop using tobacco products as advised by his or her physician because it is unreasonably difficult due to a medical condition (statement from physician attached).

I understand that if my application is approved my tobacco user premium discount will expire after twelve months, at which time I will be required to reapply for the premium discount. I understand further that if it is determined that I have provided false or misleading information in order to receive the tobacco user premium discount that I will be subject to disciplinary action 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 Daytime Phone Number

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/our health to provide to the State Employees' Insurance Board any information related to my/our use of tobacco products.

Signed: ____________________________ ____________________________
Contract Holder Date

____________________________ ____________________________
Primary Care Physician Primary Care Physician Telephone Number

Signed: ____________________________ ____________________________
Spouse (if covered under SEHIP) Date

____________________________ ____________________________
Primary Care Physician Primary Care Physician Telephone Number

Return to:	**State Employees' Insurance Board** **Wellness Department** **Post Office Box 304900** **Montgomery, AL 36130-4900**	**Toll-free: 866-838-3059** **Montgomery: 334-263-8431** **Fax: 334-517-9980**

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

Member Name (Please print)		Male ☐ Female ☐	Age: ______
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 40

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 SEIB Fitness Center's 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 qualify for the discount.

This information must be received in our office no later than November 30th. Incomplete forms are not accepted.

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

State Employees' Insurance Board
State Employees' Health Insurance Plan
Provider Screening Form

Instructions: You are to complete Section 1 of the form and your provider is to complete Section 2. The completed form must be returned to SEIB no later than October 31.

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

SECTION 1 (To Be Completed by Participant)

Name (Please print)	Appointment Date	Male ☐ Female ☐	Employee ☐ Spouse ☐ Age: ______

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

What best describes your race/ethnicity?

☐ White ☐ Black/African American ☐ Asian ☐ Other

☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ Indian or Alaska Native

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) NOTE: The requested labs below are the <u>only</u> labs considered for coverage if the participant is being seen for an SEIB wellness screening only.

Blood Pressure ________ / ________	**Height** ________ft. ________ in
Total Cholesterol ____________ mg/dL	**Weight** ____________
HDL Cholesterol ____________ mg/dL	**Waist Measurement** ____________
LDL Cholesterol ____________ mg/dL	**Waist/Ht Ratio** ____________
Triglycerides ____________ mg/dL	**BMI** ____________
Blood Glucose ____________ mg/d	

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

STATE EMPLOYEES' HEALTH INSURANCE PLAN

SPOUSAL SURCHARGE WAIVER APPLICATION

Return completed form to: State Employees' Insurance Board, P.O. Box 304900, Montgomery, AL 36130-4900
334.263.8341 / 1.866.836.9737 / Fax 334.517.9728

If your spouse is enrolled in the State Employees' Health Insurance Plan (SEHIP, you are subject to a monthly spousal surcharge of $50. In order to apply for a waiver of the spousal surcharge you must submit this application form, and the appropriate documentation, to the State Employees' Insurance Board (SEIB). Additional documentation may be required after your application is reviewed. To be eligible for the spousal surcharge waiver, one of the following must apply. Check the appropriate box below that applies to you, then sign and date this application form and return it to the SEIB with the required documentation.

____ Member Name

______________________________ Member Contract Number

I hereby declare that my:

Check one	Spouse's Status	Description	Documentation required
☐	Spouse's premiums are more than $255	My spouse is eligible for other group coverage through his/her employer but the individual premium, for the lowest cost option, is more than $255 per month.	Spouse's current or former employer must verify that the lowest cost option for the monthly individual premium is more than $255.
☐	Spouse is not eligible for insurance	My spouse is employed, but is not eligible, or not offered, group health benefits through his/her employer.	A letter, on your spouse's employer's letterhead [with an employer contact person's name and phone number], that states that your spouse is not offered employer group health benefits.
☐	Spouse is unemployed	My spouse is unemployed or retired and not covered or eligible for any other employer group health benefits.	A copy of the most recent state or federal tax return verifying your spouse's employment status*. If your spouse became unemployed or retired after the most recent state or federal tax return was filed, you must submit a signed statement which verifies that your spouse is currently unemployed or retired and not covered or eligible under any other employer group health benefits.
☐	I am a new state employee	I am a new state employee and my spouse's current or former employer offers group health benefits but the open enrollment rules of my spouse's current or former employer's health plan do not allow my spouse to enroll for coverage until _________________. The earliest date that my spouse can be covered by his/her current or former employer's health plan is _______________.	Documentation from your spouse's current or former employer or health insurance carrier verifying its enrollment rules.

I certify that the answers provided on this application form are true and correct. I also understand that if I knowingly and willfully submit false information to the SEIB in order to obtain a waiver of the spousal surcharge or fail to immediately notify the SEIB that my spouse is no longer eligible for a waiver of the spousal surcharge, I will be subject to disciplinary action, up to and including termination of employment, and I will be required to repay all surcharges that were waived as well as all claims and other expenses, plus interest, incurred by the SEHIP.

I understand that if my application is approved my spousal surcharge waiver will expire after twelve months, at which time I will be required to reapply for the premium waiver.

Signed: ______________________________ State Employee

_______________ Date

__________________________ Daytime Phone Number

Spousal Authorization

(To be signed only if spouse is eligible for other employer group coverage.)

By signing below I authorize my current or former employer or my health insurance carrier to disclose my health information (information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996) to the SEIB in order to verify the representations made on this waiver application form.

Signed:

__________________________ Spouse of State Employee

______________________________ Spouse's Employer and Contact Number

______________________________ Spouse's Employer's Group Health Insurance Plan Number

*The SEIB only requires the following information from the state or federal tax return be provided if your spouse is unemployed: The portion of the return which shows the name of the member and the member's spouse and the signature block that contains the member's spouse's signature and occupation. All other information on the tax return can be redacted (blacked out). On State Form 40 and Federal Form 1040, that information is found on the top of page 1 (member's name and member's spouse's name) and the bottom of page 2 (member's spouse's signature and occupation). If you file a Federal Form 1040EZ, that information is found on the top of page 1 (member's name and member's spouse's name) and the bottom of page 1 (member's spouse's signature and occupation). If the unemployed spouse files a separate tax return, he/she must submit his/her return showing the same information.

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: 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

RE-EMPLOYED STATE RETIREE ENROLLMENT FORM IB17

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: ( ) Ext.	

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		
	☐ Son ☐ Stepson ☐ Daughter ☐ Stepdaughter		

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
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' 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.

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

PLAN CHANGE FORM IB14 USES

To change insurance plans during open enrollment

To enroll existing employees in Supplemental Coverage, Optional Policies, SEPOP/HRA, Dental-Only Plans, Vision-Only Plan

To decline coverage on existing employees

ACTIVE EMPLOYEE PLAN CHANGE FORM

SELECT ONLY ONE

☐ **SEHIP Medical ***
To add dental attach Form IB21
To add vision attach Form IB20

☐ **BCBS Supplemental Coverage**

☐ **SEPOP/HRA**
Must attach Form IB26

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

☐ **Southland – Dental Only**

☐ **Southland – Vision Only**

☐ **Blue Cross – Dental Only**

☐ **Vision & Dental Coverage Only**

☐ **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 required for enrollment in SEHIP & dental plans.) Relationship to Employee	Birth Date	Social Security Number
			☐ Husband * ☐ Wife *		
			☐ Son ☐ Daughter ☐ Stepson ☐ Stepdaughter		
			☐ Son ☐ Daughter ☐ Stepson ☐ Stepdaughter		
			☐ Grandson ☐ Granddaughter ☐ Nephew ☐ Niece		

***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. When adding a spouse to SEHIP coverage, a spousal surcharge of $50 per month will be applied. To receive a discount you must submit a Spousal Surcharge Waiver Application (IB25). Forms are available at www.alseib.org.

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

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

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

NOTE: High deductible plans with single deductible of $1250 or more and family deductible of $2500 or more are not allowed to enroll in the supplemental coverage plan. A summary plan description of the other coverage must be provided to document the deductible amount. In addition please note the State Employees' Supplemental Coverage Plan does not coordinate with the SEIB HRA (State Employees' Premium Only Plan).

If choosing the Blue Cross Blue Shield (BCBS) Supplement coverage, you cannot 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.

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.

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.

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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.

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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 IB03 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 IB09 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: ____________________

Check all plans this change applies to: ____ **SEHIP** ____ **Supplemental** ____ **Optional** ____ **HRA**

____ **BCBS Dental** ____ **Southland Dental** ___ **Southland Vision**

DROP DEPENDENT COVERAGE **Please check appropriate box.**		**ADDITIONS – PROVIDE DOCUMENTATION** **Please check appropriate box.**	
☐	Change from Family to Single Coverage	☐	Change from Single to Family Coverage – Add Dependent(s)
☐	Cancel dependents 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 (copy of 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		
	☐ Grandson ☐ Nephew	☐ Granddaughter ☐ Niece		

*** 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 non-tobacco user discount application is submitted to the SEIB. When adding a spouse to SEHIP coverage, a spousal surcharge of $50 per month will be applied. To receive a discount you must submit a Spousal Surcharge Waiver Application (IB25). Forms are available at www.alseib.org

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 #

____
City County State ZIP

Work Telephone____________________

Home Telephone____________________

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.

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 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

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:____

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OTHER FORMS

REFUND REQUEST FORM IB10 USES

Used to request refunds of premiums paid in error.

COBRA NOTICE FORM IB11 USES

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

IB10
Revised 4/2014

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

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:______________________________

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