



ADMINISTRATIVE PROCEDURES GUIDE

State Employees' Insurance Board

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January 1, 2016

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 Alabama Battleship Commission, 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 and cash option plans) and can purchase a Vision-only plan or Cancer-only plan.

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 unless employee receives a W-2 and works an average of 30 hours per week, or 130 or more hours per month, during a designated measurement period as stipulated under the Affordable Care Act.

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 a 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,
 - 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,
 - is currently covered as a dependent under this Plan;
 - 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 active employee 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 spouse 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 the 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 the order was submitted. 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. In addition, 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.

- Pursuant to the Patient Protection and Affordable Care Act (ACA), the State of Alabama is required to treat employees who average at least 30 or more hours of service per week, or 130 or more hours of service per month, during a designated measurement period as full-time employees for health insurance purposes. For more details see “Memos to State Agencies on the Affordable Care Act – Employer Shared Responsibility Provisions” on the SEIB website www.alseib.org.
- **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, cancer 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 the basic medical plan and pay a 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	100%	0% + 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 **no** insurance merely because their employment status changed to part-time. If an employee elects not to be covered while a part-time employee, a Membership Status Change Form should be completed requesting coverage cancellation. Do not use the “decline coverage” option on the enrollment form.

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

- 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 15; begins with Public Safety August 16. 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 spouse terminates State employment on January 8 must add dependent coverage to be effective February 1, since his spouse 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 or within 60 days of gaining a new dependent through marriage, birth or adoption.

A request for Special Enrollment must include:

- a letter requesting special enrollment submitted to the SEIB within 30 days of the loss of other coverage or within 60 days of gaining a new dependent, 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.) or
 - 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 form 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 for active employees are processed electronically once they are changed on payroll with the employee's agency.

II. TERMINATION OF COVERAGE

A. When Coverage Terminates

Coverage under the SEHIP 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 the SEHIP is discontinued.
- On the last day of the month in which you decline coverage or opt out of the SEHIP
- On the last day of a designated stability period, in the case of an employee who receives insurance as a result of working 30 or more hours per week or 130 or more hours per month during a designated measurement period.

Coverage under the SEHIP 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.
- On the last day of a designated stability period, in the case of a dependent who receives insurance on the basis of a member who works 30 or more hours per week or 130 or more hours per month during a designated measurement period.

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. 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. Employees on FMLA who want to continue coverage 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 we 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 SEIB 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, Optional Plans, Dental Plan, Cancer Plan or the Vision Plan will be required to pay premiums to continue coverage.

Employees on LWOP will be responsible for the LWOP premiums.

- **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). 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 is available for download via the SEIB website to the agency's **authorized** payroll/personnel officers. The state share is charged to the payroll fund designated in GHRS for the employee based on accounting codes in GHRS.

All employee payroll premium refunds will be credited back to the employee in their paycheck 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 334.263.8371 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 Fund.

B. Eligible Dependent - see page 5.

C. Enrollment/Continuation

- A retiring employee may elect coverage under the SEHIP, 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 at the time of their retirement may enroll 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 must 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 group 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 or within 60 days of gaining a new dependent through marriage, birth or adoption.

A request for Special Enrollment must include:

- a letter requesting special enrollment submitted to the SEIB within 30 days of the loss of other coverage or within 60 days of gaining a new dependent, 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. Provisions for Medicare

The SEHIP remains primary for members until the member is entitled to Medicare. Health benefits will be modified when a member or their dependent becomes entitled to Medicare. Upon entitlement to Medicare, the SEHIP will be the secondary coverage and Medicare will be the primary coverage (unless otherwise provided under the Medicare secondary payer regulations).

A Medicare retiree and/or Medicare dependent should have both Medicare Parts A and B to have adequate coverage with the State of Alabama.

If a retiree or dependent becomes entitled to Medicare because of a disability before age 65, he/she must notify the SEIB.

NOTE: The SEHIP is not a supplement to Medicare.

Medicare Part B

Retirees who are eligible for Medicare primary coverage but do not have Medicare Part B will:

- Not receive State primary coverage for services that would have been covered by Medicare Part B if they are enrolled as a Medicare retiree. State primary coverage for these services will be “carved out” and the Medicare retiree will be responsible for the payment of these claims.
- Pay the SEHIP an amount equal to the Medicare Part B premium in addition to the regular non-Medicare premium if they are enrolled as a non-Medicare retiree. These retirees have until the next available Medicare enrollment period to enroll in Medicare Part B. As of that date, the retiree will be changed to Medicare primary for Medicare Part B services and the State coverage will become secondary.

If the additional premium equal to the Medicare Part B premium is not paid to the SEHIP, State primary coverage will be “carved out” for all benefits Medicare Part B would have paid and the retiree will be responsible for the payment of these claims.

Medicare Part D Prescription Drug Coverage

Prescription drug benefits for Medicare retirees are provided through the SEHIP Employer Group Waiver Plan (EGWP). The SEHIP EGWP is a Medicare Prescription Drug (Part D) plan that is in addition to the coverage under Medicare Part A or Part B.

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

If the member retired after September 30, 2005, but before January 1, 2012, he/she will be subject to a sliding scale premium structure based on 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 will pay 100% of the “employer contribution” of the premium. Each year less than 25, the amount the State will pay toward the “employer contribution” will 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” will be increased by 2% and the employee contribution reduced accordingly. NOTE: The retiree sliding scale is not applicable to premium discounts.

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 1975) 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 1975, 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 the member retired on or after January 1, 2012, he/she will be subject to a sliding scale premium structure based on 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 premium discounts.

Years of creditable coverage is the number of years and months an employee is covered under the SEHIP and is determined by the SEIB. Creditable coverage may also be allowed for the following service time:

- service in the United States armed forces;
- as a part-time employee prior to October 1, 2005;
- service as an employee as defined in Sections 16-25A-1 and 16-25A-11 Code of Alabama 1975;
- as a full time employee of a local legislative delegation office which participates in the Employees’ Retirement System if the employee is under the state employees’ insurance plan on June 14, 2011;
- 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.
- as a juvenile probation officer provided the Administrative Office of Courts contributes an amount equal to the amount appropriated by the state to fund benefits for such retired employees; or
- as an employee of the USS Alabama Battleship Commission provided that the USS Alabama Battleship Commission 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.

I. 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.

J. Re-Employed State Retiree

Re-employed State retirees must work an average of ten (10) hours or more per week to be eligible for re-employed State retiree coverage in the SEHIP. Re-employed State retirees, who work less than ten (10) hours per week on average, may continue their retiree coverage in the SEHIP but will not be classified as re-employed State retirees for health insurance purposes.

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 submit a Re-employed State Retiree Health Insurance Form to the SEIB if they are expected to work 10 hours or more on average per week.

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.

K. Retired Employee Name Changes

Name changes for retired employees must be made in writing and submitted to the SEIB.

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 of the primary coverage plan benefits. Participants may elect individual or family coverage.

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

Employees who decline coverage in the SEHIP and enroll in the State Employees' Supplemental Coverage Plan may not enroll in the SEIB Optional Insurance Plan or PCO. The primary coverage cannot be with SEHIP, PEEHIP, LGHIP, TRICARE or Medicare. In addition, you are not eligible for the State Employees Supplemental Coverage Plan if your primary health plan is a high deductible plan (i.e. a plan with in-network deductibles of \$1,250 or more for single coverage or \$2,500 or more for family coverage). Supplemental coverage plan limits reimbursement on deductibles to \$300 on inpatient hospital and \$1,250 per individual covered for all other deductibles.

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 (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 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 12 months. If enrollment is effective on any day other than January 1, coverage will remain in effect through the end of the next full plan year.

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

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 Plan, Vision Plan, Cancer Plan or PCO.

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

- Premium Cash Option (PCO)/HRA

The PCO 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 SEHIP who has opted out of the SEHIP is eligible to enroll in the PCO.

Enrollment in the PCO 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 PCO at any time during the year by completing Form IB26.

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

- Dental Coverage (Dependent documentation required)

Dental coverage is offered as a separate benefit with a monthly premium for single or family coverage. The State Employees' Dental Insurance Plan (Blue Cross plan) and the State Employees' Southland Dental Plan are available. Enrollment applications are accepted for date of hire, open enrollment or special enrollment. Documentation is required. A minimum enrollment of 12 months is required for employees and dependents. Employees can either enroll in conjunction with SEHIP, Supplemental, PCO, Cancer Plan, or the Vision Plan or solely in a dental plan.

- Vision Coverage (Dependent documentation required)

Southland Vision coverage is available with a monthly premium for single or family coverage. 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 in conjunction with SEHIP, Supplemental, PCO, Cancer Plan or either dental plan or solely in a vision plan.

- Cancer Coverage (Dependent documentation required)

Beginning January 1, 2016, Southland Cancer coverage is available with a monthly premium for single or family coverage. 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 in conjunction with SEHIP, Supplemental Plan, PCO, either dental plan, vision plan, or solely in a cancer 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 submit a copy of their Federal Income Tax Return from the previous year, copies of any 1099's and W-2's attached to their Federal Income Tax Return and a copy of their most recent pay stub.

The premium discount will be applied as follows:

Greater than 300% of the FPL – employee pays 100% of the employee contribution
251%-300% of the FPL – employee contribution reduced 10%
201%-250% of the FPL – employee contribution reduced 20%
151%-200% of the FPL – employee contribution reduced 30%
101%-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 must 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) or part-time employees' premiums. Dental, Cancer, and Vision coverage premiums are not discounted.

Employees who have discounted premiums through the Federal Poverty Level 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 Premium Discount**

If you and your covered spouse both use tobacco products, you and your covered spouse will each be subject to a separate tobacco user premium of \$60. The tobacco user premium will be applied as follows:

1. If only you or your covered spouse, but not both, use tobacco products your tobacco user premium will continue to be \$60 per month.
2. If you and your covered spouse both use tobacco products, your monthly tobacco user premium will be \$120 (\$60 for you and \$60 for your covered spouse).

If you (and/or your spouse if covered as a dependent under SEHIP) have not used tobacco products in the last twelve months, you may be eligible for a premium discount. In order to obtain the discount you must submit a completed non-tobacco user premium discount application to the SEIB. You may also qualify for the discount if you submit an annual tobacco user premium discount application (IB06) along with acceptable documentation to the SEIB each year verifying that you (and/or your spouse if covered as a dependent under SEHIP):

1. have completed an SEIB approved tobacco usage cessation program; or
2. cannot stop using tobacco products as advised by your 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**

All active employees, covered spouses of active employees, non-Medicare retirees and covered non-Medicare spouses of retirees that use the State Employees' Health Insurance Plan (Group 13000) as their primary insurance plan are eligible for a wellness premium discount. Each wellness plan year is November 1 through October 31. Every eligible participant must be screened either through the SEIB's worksite wellness screening program, at your local Health Department, a certified Pharmacy location and/or by a healthcare provider (through the submission of a Provider Screening Form).

Risk factors are blood pressure, total cholesterol, glucose, and body mass index. Members are considered to be "at risk" if their:

1. blood pressure systolic reading is 160 or above, or diastolic reading is 100 or above;
2. total cholesterol reading is equal to or above 250;

3. glucose reading is equal to or above 200;
4. body mass index is equal to or above 40.

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 co-pay waiver referral. The office visit co-pay waiver is only for members covered under Group 13000 and only waives the office visit co-pay. The member is responsible for all other applicable co-pays, such as lab test co-pays. Only one office visit co-pay waiver is allowed within a screening period regardless of how many times the member is issued a referral. **This co-pay waiver is not applicable at an emergency room or urgent care center.**

A member can earn the wellness premium discount within the wellness plan year in the following ways:

1. Submission of health screening results through a SEIB wellness program indicating that the member is not at risk for one or more of the above health risk indicators;
2. Submission of a completed and signed office referral form indicating that the member has been counseled by a healthcare provider for his/her identified risk(s) indicators;
3. Submission of participation in a YMCA, Gold's Gym, Curves or other SEIB approved program(s). The member must provide documentation of his/her participation;
4. Provide valid proof that the member is self-managing and has made improvement in their identified risk(s). The member must provide documentation of his/her improvement; or
5. Submission of a completed Provider Screening Form.

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 or 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), the member must meet the criteria no later than October 31 of the preceding year. New employees will have 60 days from date of hire to qualify 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 qualify for the wellness premium discount.

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

- **Spousal Surcharge Waiver**
Employees and retirees whose spouses are enrolled in the SEHIP will be charged a \$50 per month surcharge if their spouses are eligible for other insurance coverage but chooses to be covered under the SEHIP. Spouses who are eligible for other coverage must enroll in that other coverage or pay the \$50 per month spousal surcharge. The surcharge will not apply if the spouse's other individual coverage monthly premium is \$255 or more.

In order to have the spousal surcharge waived, the member must complete the "Spousal Coverage Certification Form" available on the SEIB's website and submit the completed form, with appropriate documentation, to the SEIB.

It is the responsibility of the member to notify the SEIB immediately should a covered spouse become eligible for coverage through his or her employer during the waiver period. Any employee or retiree who knowingly and willfully submits false information to the SEIB in order to obtain a waiver of the Spousal Surcharge or fails to immediately notify the SEIB that he or she is no longer eligible for a waiver of the Spousal Surcharge will be subject to disciplinary action, up to and including termination of coverage, and will be required to repay all surcharges as well as all claims and other expenses, plus interest, incurred by the SEHIP.

V. SEIB PAYROLL/PERSONNEL ONLINE SYSTEM OVERVIEW

The State Employees Insurance Board (SEIB) is offering an online account specifically for payroll/personnel officers that will help expedite the health insurance enrollment process for State Employees. The new account will replace the

previous Payroll/Personnel account that was offered. SEIB will allow payroll/personnel officers at each State Agency to apply for an online account in order to access the information listed below.

- A. Employee Change Request Portal - allows the payroll/personnel officer to view all pending or completed change requests that have been submitted within their Agency. The requests are separated into Pending Requests and Completed Requests.
- B. New Employee Enrollment – allows for completing a new employee form online in a central place. The online form may be completed one time and will accommodate applying for multiple policies and dependents in one process.
- C. Subscriber Information Management – Includes a flexible search to allow payroll/personnel officers to assist existing employees with making changes to their coverage. The information management page is the central access point for making changes and viewing information for existing subscribers. The following functions can be performed using the subscriber information page:
 - 1. Change Plan Information
 - Change/Update Employment Information
 - Request an Employee Transfer
 - Employment Termination Notification
 - Change LWOP Status
 - 2. Add New Policy
 - 3. Cancel Policy
 - 4. Add Dependent/ Reinstate Dependent
 - 5. Cancel Dependent
- D. Supplemental Billing Statements - View the supplemental billing statements for the agency.
- E. The SEIB Payroll and Personnel Officer Authorization Request form needs to be completed and returned to SEIB so that you may be granted access to this new account.

Questions or concerns about using the system, general functionality, or problems/errors encountered can be emailed to webmaster@alseib.org or by phone to (334)263-8411.

ENROLLMENT FORM IB02 USES

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

PCO/HRA FORM IB26

Attach this form with IB02 when enrolling in PCO

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

SOUTHLAND CANCER ENROLLMENT/CANCELLATION FORM IB23

Attach this form with IB02 when adding cancer coverage
To enroll/cancel cancer 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.

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,
 - 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 spouse 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: 334.263.8541

Premium Cash Option 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: 334.263.8512

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 your spouse's group health plan for which you will be seeking reimbursement of premiums:		Group Number:
Spouse's Employer Name:	Spouse's Name:	
<p>What is the Premium Cash Option (PCO)? Formerly known as the State Employees' Premium Only Plan, the PCO 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.</p> <p>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 PCO.</p> <p>What's the benefit to enrolling in the PCO? When you enroll in the PCO 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.</p> <p>Can PCO Benefit Dollars be used for any health care premium? No. PCO 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).</p> <p>Will Benefit Dollars in your PCO account roll over each year? Yes. If you don't spend all your Benefit Dollars in a Plan Year, any unused PCO Account balance rolls over into the next Plan Year. In this manner your PCO Account may "grow" almost like a savings account.</p> <p>How do you enroll? You can enroll in the PCO 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 PCO.</p> <p>How do you dis-enroll? You can dis-enroll in the PCO and re-enroll in the SEHIP at any time during the year. When you dis-enroll in the PCO or terminate your employment, any Benefit Dollars in your PCO Account will revert back to the Plan.</p>		
Important – Read Carefully Before Signing		
<p>The PCO 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 PCO and all information furnished is true and complete.</p>		
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		
Mailing Address		<input type="checkbox"/> Blue Cross Dental <input type="checkbox"/> Southland Dental A minimum enrollment of 12 months required for employees/ dependents <input type="checkbox"/> Single Coverage - \$8/monthly <input type="checkbox"/> Family Coverage - \$15/monthly (List dependents below.) (Documentation is Required) <input type="checkbox"/> Cancel Coverage		
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
			<input type="checkbox"/> Male Spouse <input type="checkbox"/> Female Spouse		
			<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Stepson <input type="checkbox"/> Stepdaughter		
			<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Stepson <input type="checkbox"/> Stepdaughter		
			<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Stepson <input type="checkbox"/> Stepdaughter		
			<input type="checkbox"/> Grandson <input type="checkbox"/> Granddaughter <input type="checkbox"/> Nephew <input type="checkbox"/> Niece		
			<input type="checkbox"/> Grandson <input type="checkbox"/> Granddaughter <input type="checkbox"/> Nephew <input type="checkbox"/> Niece		

AFFIRMATION AND RELEASE

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

 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 a divorced or common-law spouse).
2. A child under age 26, only if the child is:
 - a. your son or daughter,
 - b. a child legally adopted by you or your spouse,
 - c. your stepchild,
 - 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: 334-263-8541**

**State Employees' Insurance Board
Southland National Supplemental Vision Insurance
Enrollment/Cancellation Form**

SUBSCRIBER INFORMATION

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

E-mail Address: _____

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

AFFIRMATION AND RELEASE

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

Employee Signature

Date

GENERAL INFORMATION

Eligible Dependent

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

1. Your spouse (excludes a divorced or common-law spouse).
2. A child under age 26, only if the child is:
 - a. your son or daughter,
 - b. a child legally adopted by you or your spouse,
 - c. your stepchild,
 - 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 spouse or other dependents if they are independently covered as a State employee.

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

State Employees' Insurance Board Southland National Supplemental Cancer Insurance Enrollment/Cancellation Form

SUBSCRIBER INFORMATION

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

E-mail Address: _____

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

AFFIRMATION AND RELEASE

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

Employee Signature

Date

GENERAL INFORMATION

Eligible Dependent

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

1. Your spouse (excludes divorced or common-law spouse).
2. A child under age 26, only if the child is:
 - a. your son or daughter,
 - b. a child legally adopted by you or your spouse,
 - 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 spouse or other dependents if they are independently covered as a State employee.

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

New Employee – Open Enrollment Salary Reduction Agreement Premium Conversion Plan	
<p>This form allows you to enroll and/or opt out of the Premium Conversion Plan during Open Enrollment only.</p>	
Employee Information (please print)	
Name:	Social Security Number:
Address:	City, State, Zip:
Work Telephone Number:	Home Telephone Number:
<p>() 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.</p> <p>() I do not elect to enroll in the Premium Conversion Plan.</p>	
Terms and Conditions	
<p>I understand that:</p> <p style="margin-left: 40px;">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.</p> <p style="margin-left: 40px;">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.</p> <p style="margin-left: 40px;">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.</p> <p style="margin-left: 40px;">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.</p> <p style="margin-left: 40px;">This Agreement is subject to the terms of the Flexible Benefits Plan, as amended.</p>	
Certification	
<p>I hereby certify that I have completely read and fully understand the terms and conditions of this form.</p>	
<p>_____</p> <p>Employee Signature</p>	<p>_____</p> <p>Date</p>

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

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

Post Screening Qualification 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	

Check the box or boxes below regarding the tobacco usage status of you and/or your covered spouse:

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

- My spouse is covered under SEHIP and is currently not using and has not used tobacco products in any form (cigarettes, cigars, pipe, oral tobacco products, etc.) within the last 12 months.

If I receive a non-tobacco user discount I understand that if it is determined that I have used tobacco products within the last 12 months or if I 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 coverage, and will be required to repay all discounts as well as all claims and other expenses incurred by the SEHIP, plus interest.

If my spouse receives a non-tobacco user discount I understand that if it is determined that my spouse has used tobacco products within the last 12 months or if my spouse starts using tobacco products subsequent to the date of this application and I fail to notify the State Employees' Insurance Board, that I will be subject to disciplinary action, including termination of coverage and will be required to repay all discounts as well as all claims and other expenses incurred by the SEHIP, plus interest.

Signed: _____
Contract Holder

Date: _____

Authorization

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

Signed: _____
Contract Holder

Date: _____

Signed: _____
Spouse (if covered under SEHIP)

Date: _____

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

STATE EMPLOYEES' HEALTH INSURANCE PLAN ANNUAL TOBACCO USER PREMIUM DISCOUNT APPLICATION

Name of Contract Holder	Contract Number
--------------------------------	------------------------

Declaration

Check all the appropriate boxes 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 must be attached).
- My spouse has completed an SEIB approved tobacco cessation program (verification must be 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 must be 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 must be 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
Signed:	Contract Holder's Primary Care Physician	Primary Care Physician's Telephone Number
Signed:	Spouse (if covered under SEHIP)	Date
Signed:	Spouse's Primary Care Physician	Spouse's Primary Care Physician's Telephone Number

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

State Employees' Health Insurance Plan Post Screening Qualification Form

This form is only to be used to provide proof that you have addressed identified health risk(s).

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

I have participated in a wellness screening at the worksite, county HD, or pharmacy and one or more of the following health risk(s) was 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

You are still eligible to earn the wellness premium discount by providing proof that you have addressed your health risk(s) in one of the following ways. The identified health risk must be addressed on or before October 31st for a January 1 premium discount.

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:*

- A Wellness Program Office Visit Referral that has been signed by my healthcare provider, or
- A completed Provider Screening Form documenting my results.

I participated in a Physician Supervised Weight Management/Nutritional 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 October 31.
Incomplete forms will not be processed.**

**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 Provider Screening Form

Instructions: You are to complete Section 1 of the form and your provider is to complete Section 2. The screening must be completed no later than October 31st and submitted to SEIB by November 15th.

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

SECTION 1 (To Be Completed by Participant)

Name (Please print)		Screening Date	Male <input type="checkbox"/>	Employee <input type="checkbox"/>	Spouse <input type="checkbox"/>	Retiree <input type="checkbox"/>
			Female <input type="checkbox"/>	Age: _____		
Insurance Number	Group #	Last 4 SSN #	Date of Birth (00/00/00)	Day Time Phone Number ()		

What best describes your race/ethnicity?

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

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

- High Cholesterol High Blood Pressure Diabetes

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

- High Cholesterol High Blood Pressure Diabetes

SECTION 2 (To Be Completed by Provider) NOTE: The requested labs below are the only labs considered for coverage if the participant is being seen for an SEIB wellness screening only.

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

Provider's Name: (Please print) _____

Provider Signature: _____

Provider Address: _____

Please return completed form to:
STATE EMPLOYEES' INSURANCE BOARD
WELLNESS DIVISION
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 334.263.8541

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
<input type="checkbox"/>	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.
<input type="checkbox"/>	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.
<input type="checkbox"/>	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.
<input type="checkbox"/>	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 coverage 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 federal income tax filing, W-2s and pay stubs must be attached)
Please use **black** ink.

1. Employee/Retiree Information

Name:	First	Middle	Last	Contract Number
Address				
City, State, Zip Code				
Home Phone ()		Work Phone ()		Cell Phone ()
Check Marital Status: Single <input type="checkbox"/> Married <input type="checkbox"/>			Email Address:	

2. Income: List the current total monthly income for each member of your household. This includes all sources of income that are included on Federal Income Tax Return Form 1040, 1040A or 1040EZ. **You must submit a copy of your Federal Income Tax Return from the previous year, copies of any 1099's and W-2's attached to your Federal Income Tax Return and your most recent pay stub or other necessary documentation verifying your current household income. W-2 forms will not be accepted in the place of pay stubs. If you were married and did not file a joint return, you must also submit a copy of your spouse's Federal Income Tax Return from the previous year with copies of all supporting 1099's and W-2's in order for the application to be processed.**

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

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
A.		SELF	
B.		SPOUSE	
C.			
D.			
E.			
F.			
G.			
H.			

4. Affirmation I declare that the above statements and answers are true, complete, accurate 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 (with all required documentation) to:

**State Employees' Insurance Board
Attention: Accounting
P.O. Box 304900
Montgomery, AL 36130
Phone: 334.263.8379
Fax: 334.263.8720**

RE-EMPLOYED STATE RETIREE ENROLLMENT FORM IB17

Use when a retiree is re-employed with a State agency.
Complete this form only if retiree will be working 10 hours or more per week.

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,
 - 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 spouse 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 / FAX: 334.263.8541

PLAN CHANGE FORM IB14 USES

To change insurance plans during open enrollment

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

To decline coverage on existing employees

ACTIVE EMPLOYEE PLAN CHANGE FORM

SELECT (CHECK) ONLY ONE

SEHIP Medical * To add dental attach Form IB21 To add vision attach Form IB20 To add cancer attach Form IB23	BCBS Supplemental Coverage To add dental attach Form IB21 To add vision attach Form IB20 To add cancer attach Form IB23	Southland Optional Policies Vision / Dental / Cancer / Hospital Indemnity	PCO/HRA Must attach Form IB26 To add dental attach Form IB21 To add vision attach Form IB20 To add cancer attach Form IB23
		Vision, Dental & Cancer Only Attach Forms IB20, IB21 & IB23	Vision & Dental Coverage Only Attach Forms IB20 and IB21
Southland – Dental Only	Southland – Vision Only	Southland – Vision & Cancer Only Attach Forms IB20 and IB23	Decline All Coverage
Southland –Cancer Only	Dental & Cancer Only Attach Forms IB21 and IB23	Blue Cross – Dental Only	

SUBSCRIBER INFORMATION

Name (First, Middle Initial, Last)		Sex:	Effective Date of Coverage
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 all plans except Supplemental. Relationship to Employee
			<input type="checkbox"/> Male Spouse* <input type="checkbox"/> Female Spouse *
			<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Stepson <input type="checkbox"/> Stepdaughter
			<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Stepson <input type="checkbox"/> Stepdaughter
			<input type="checkbox"/> Grandson <input type="checkbox"/> Granddaughter <input type="checkbox"/> Nephew <input type="checkbox"/> Niece
Birth Date			
Social Security Number			

***IMPORTANT:** To be eligible for the non-tobacco and/or wellness discount, you must submit a completed Non-Tobacco User Discount Application and meet the requirements of the Wellness Program. When adding a spouse to SEHIP coverage, a spousal surcharge of \$50 per month will be applied. To receive a discount you must submit a completed Spousal Surcharge Waiver Application (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
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NOTE: Certain restrictions apply to high deductible plans. 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 (Premium Cash Option).

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

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

AFFIRMATION AND RELEASE

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

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,
 - 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 spouse or other dependents if they are independently covered as a State employee.

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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 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 a divorced or common-law spouse).
2. A child under age 26, only if the child is:
 - a. your son or daughter,
 - b. a child legally adopted by you or your spouse ,
 - c. your stepchild,
 - 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 spouse or other dependents if they are independently covered as a State employee.

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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.

**SEIB OFFICE USE ONLY
OK TO REFUND**

Mo/Day/Year By

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

REFUND REQUEST

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

Agency Identification Data

Employee Identification Data

Agency name _____

Employee name _____

Agency No. _____

Address: _____

City: _____ State: _____ ZIP: _____

Flex Plan: Yes _____ No _____

Social Security # _____

Refund amount \$ _____ Coverage Period: _____ through _____

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

____ Employee terminated: Date _____

____ Employee retired: Date _____

____ Employee began leave without pay: Date _____

____ Employee notified SEIB on _____ to drop coverage on _____ Employee ____ Dependent
Effective date _____ (attach change form)

____ Dependent died: Date _____

____ Employee died: Date _____

____ Coverage was paid/deducted in error on _____ Employee ____ Dependent
for the period of _____ through _____

____ Employee status changes to ____ full time ____ part-time: Date _____

____ Other reason. Please explain _____

Signature of Official requesting refund

COBRA

Employer Notice Memo
Or
Send a copy of Form 11

_____		_____	
Name of Employee		Social Security Number	
_____		_____	
Number and Street or P. O. Box	City	State	ZIP

The above identified employee of _____ is covered in the SEHIP and under applicable COBRA provisions 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: _____

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