

2010 CHANGE FORM LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM

SUBSCRIBER INFORMATION

Name (First, Middle Initial, Last)		Sex	Date of Birth
Social Security Number	Contract Number	Home Telephone Number ()	Work Telephone Number () Ext.

CHANGE: MAILING ADDRESS To: _____
 NAME From: _____ To: _____
 E-MAIL ADDRESS To: _____

RATE: <input type="checkbox"/> Retired Subscriber (Not Medicare Participant) <input type="checkbox"/> No Dependent <input type="checkbox"/> Dependent Medicare <input type="checkbox"/> Dependent not Medicare	RATE: <input type="checkbox"/> Retired Subscriber (Medicare Participant) <input type="checkbox"/> No Dependent <input type="checkbox"/> Dependent Medicare <input type="checkbox"/> Dependent not Medicare
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Note: If in your rate above you selected: **Retired Subscriber (Medicare Participant)** or **Dependent Medicare**, you must provide a copy of your Red, White, and Blue Medicare Card.

DROP DEPENDENT COVERAGE <input type="checkbox"/> Change from Family to Single Coverage <input type="checkbox"/> Cancel dependent(s) listed below from Family Coverage	ADDITIONS – PROVIDE DOCUMENTATION – (270-day Waiting Period for pre-existing conditions. Attach a Certificate of Creditable Coverage to waive all or a portion of the waiting period for pre-existing conditions.) ** Please read important information on the back. <input type="checkbox"/> Change from Single to Family Coverage. Add dependent(s)** <input type="checkbox"/> Add dependent(s) listed below to Family Coverage **
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REASON FOR CANCEL MONTH/DAY/YEAR <input type="checkbox"/> Death _____ <input type="checkbox"/> Divorce _____ <input type="checkbox"/> Dependent no longer eligible _____ Explain: _____ <input type="checkbox"/> Other: _____ Explain: _____	REASON FOR ADDITION MONTH/DAY/YEAR <input type="checkbox"/> Marriage, date of marriage _____ <input type="checkbox"/> Birth or Adoption of Child _____ <input type="checkbox"/> Other _____ Explain: _____
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First Name	Initial	Last Name	Documentation is required. See back of form. Relationship to Employee	Date of Birth	Social Security Number
			<input type="checkbox"/> Husband <input type="checkbox"/> Wife		
			<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		

For additional dependents, please list the information on a separate sheet and attach to this form.

<p style="text-align: center;">TO BE COMPLETED BY EMPLOYER</p> Effective Date of Change: _____ / _____ / _____ _____ <p style="text-align: center;">Local Government Unit Name</p> _____ <p style="text-align: center;">Account Number</p> _____ _____ <p style="text-align: center;">Signature of Insurance Clerk Date</p>	<p style="text-align: center;">AFFIRMATION AND RELEASE</p> 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. _____ <p style="text-align: center;">Employee Signature Date</p>
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* A "pre-existing medical condition" is any condition, no matter how caused, for which you received medical advice, diagnosis, care or for which treatment was recommended or received during the six months before your coverage began.

GENERAL INFORMATION

ELIGIBLE DEPENDENTS

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

1. Your spouse (excludes divorced or common law spouse)
2. An unmarried child under age 19, only if the child is:
 - a. your son or daughter
 - b. a child legally adopted by you (including any probationary period during which the child is required to live with you)
 - c. your stepchild
 - d. your grandchild, niece or nephew for whom the court has granted you legal custody (provided the child is not eligible for any other group health insurance benefits).
2. Children ages 19 through 25 who are full-time unmarried students attending an accredited institution. An annual student verification letter from the institution must be filed with the SEIB.
3. An incapacitated dependent will be considered for coverage to any age provided the 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 upon the subscriber for 50% or more support,
 - e. is otherwise eligible for coverage as a dependent except for age, and
 - f. the condition must have occurred prior to the dependent's 19th birthday (unless already covered by the SEIB as a student, in which case the condition must have occurred prior to the dependent's 26th birthday).

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 otherwise 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:
 - i. spouse's employer ceases operations, or
 - ii. spouse's loss of eligibility due to termination of employment or reduction of hours of employment, or
 - iii. spouse's employer stopped contribution to coverage,
 - a. a change form is submitted to the SEIB within 30 days of the incapacitated dependent's loss of other coverage, and
 - b. incapacitation status is approved by Medical Review.

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.

Exclusion: You may not cover your wife, husband or other dependents if they are insured or if they are eligible to be insured as an active employee in the Local Government Health Insurance Program.

WAITING PERIODS

The Health Insurance Portability and Accountability Act (HIPAA) provides that if you are covered by another plan before becoming covered by the SEIB, the time you were covered will be credited toward the 270-day waiting period for pre-existing conditions, if:

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

In order to waive all or a portion of the waiting period for pre-existing conditions, you must submit a Certificate of Creditable Coverage when you enroll.

**STATE EMPLOYEES' INSURANCE BOARD
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