PLAN CHANGE FORM

A. Subscriber Information

Name (First, Middle Initial, Last):			Gender:	Social Security Number:		Date of Birth:
Street Address:			City:		State:	ZIP Code:
Home Phone Number:	Cell Phone Number:	Work Phone Number:	E-Mail Address:			
Effective Date of Coverage:	Are you or your spouse eligible for other group health insurance through a spouse, other employer, or previous employer? ☐ Yes ☐ No					

B. Enrollment

(see page 3 for more information on coverage options)

Health Coverage – Choose <u>one</u> health plan/option or decline all health coverage:

- ☐ SEHIP Medical (administered by BCBS)
  - ☐ Single
  - ☐ Family (complete section C)
- ☐ Medicare Advantage (Medicare Only)
  - ☐ Single
  - ☐ Family (complete section C)
- ☐ Supplemental Plan (complete Section D)
  - ☐ Single
  - ☐ Family (complete section C)
- ☐ Optional Plan (complete Section D)
  - ☐ Single
  - ☐ Family (complete section C)
- ☐ Premium Cash Option (complete Section D) (active employees only)
- ☐ Decline All Health Coverage

Stand-alone Dental Coverage -- Choose <u>one</u> dental plan or decline all dental coverage by leaving the boxes empty:

- ☐ BCBS Dental Plan*
  - ☐ Single $8 per month
  - ☐ Family $15 per month (complete section C)
- ☐ Southland Dental Plan*
  - ☐ Single $8 per month
  - ☐ Family $15 per month (complete section C)

*A minimum enrollment of 12 months is required.

If no selection is made, the SEIB will not add dental coverage.

Other stand-alone coverages – Choose one or both policies or decline coverage by leaving the boxes empty:

- ☐ Southland Cancer Policy*
  - ☐ Single $12 per month
  - ☐ Family $24 per month (complete section C)
- ☐ Southland Vision Policy*
  - ☐ Single $12 per month
  - ☐ Family $24 per month (complete section C)

*A minimum enrollment of 12 months is required.

If no selection is made, the SEIB will not add cancer or vision coverage.

C. Dependent Information - Attach Separate Sheet, if necessary

First Name Middle Initial Last Name	Relationship to Employee*	Gender	Date of Birth	Social Security Number	**Coverage**** Add to Health	Add to Dental	Add to Cancer	Add to Vision
					☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐

Coverage**
(Please check appropriate box to add dependent to coverage)

* Documentation of relationship to employee is required for all plans except the Supplemental Plan (e.g., social security number, marriage certificate, birth certificate, court decree).

** Health means the health plan chosen in Section B, above. Dental means the stand-alone dental plan chosen in Section B, above. Cancer and Vision mean the stand-alone Southland Cancer or Southland Vision policies chosen in Section B, above. If you did not choose a health, dental, cancer, or vision plan in Section B, leave that coverage box empty.

IMPORTANT: To be eligible for the wellness discount, you must 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.

Direct payment MUST be made for any premiums that will not be payroll deducted.

D. Additional Coverage

☐ Medicare Part A ☐ Medicare Part B ☐ Other (specify) _____

E. Primary Insurance Information

(must be completed if choosing the Supplemental Plan, Optional Plan, or Premium Cash Option)

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

Certain restrictions apply to high deductible health plans. A summary plan description of the other coverage must be provided to document the deductible amount. In addition, please note the Supplemental Plan does not coordinate with the Premium Cash Option.

If choosing the Supplemental Plan, you cannot maintain your primary coverage through the SEHIP, Local Government Health Insurance Plan, Public Education Employees' Health Insurance Plan, TRICARE, Medicaid, Medicare or the Marketplace.

For Supplemental Plan participants, you may need to manually file claims with BCBS for pharmacy benefit reimbursements as BCBS may not coordinate with your primary insurance carrier.

PREMIUM CASH OPTION (PCO) DISCLOSURE – Active Employees Only
Sign and Date only if enrolling in the PCO

Important – Read Carefully Before Signing

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.

Employee Signature: _____ Date: _____

AFFIRMATION AND RELEASE
Sign and Date for all chosen coverages

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: _____

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