RE-EMPLOYED STATE RETIREE HEALTH INSURANCE FORM

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

☐ **Decline Coverage**

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

List covered dependents below.

First Name Middle Initial Last Name	Relationship to Employee		Birth Date	Social Security Number
	☐ Male Spouse	☐ Female Spouse		
	☐ Son ☐ Stepson	☐ Daughter ☐ Stepdaughter		
	☐ Son ☐ Stepson	☐ Daughter ☐ Stepdaughter		
	☐ Son ☐ Stepson	☐ Daughter ☐ Stepdaughter		

IMPORTANT: Please complete this form only if you are going to be working 10 hours or more a week. If you are working less than 10 hours per week, your current status will not change.

Remember: If you or your dependents have Medicare, upon returning to work, Medicare becomes secondary to the SEHIP.

TO BE COMPLETED BY EMPLOYER

EMPLOYMENT STATUS:

_____Full Time _____3/4 Time _____ 1/2 Time _____1/4 Time

DATE STARTED TO WORK: _____

_____
Signature of Payroll Clerk

_____
State Agency Date

AFFIRMATION AND RELEASE

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

_____ _____
Employee Signature Date

Return to:
State Employees' Insurance Board
201 South Union Street, Suite 200
PO Box 304900
Montgomery, AL 36130-4900
334-263-8341 / 1-866-836-9737 / Fax: 334-263-8541

General Information

Eligible Dependent
The term "dependent" includes the following individuals:

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. legally adopted by you or your spouse,
   c. your stepchild, or
   d. a dependent for whom you, or your spouse, has legal and physical custody granted by a court of competent jurisdiction.
3. An incapacitated dependent child* over age 25 will be considered for coverage provided dependent is:
   a. unmarried,
   b. permanently mentally or physically disabled or incapacitated,
   c. had the condition prior to the dependent's 26th birthday,
   d. incapable of self-sustaining employment,
   e. dependent on you for 50% or more finanical support,
   f. otherwise eligible for coverage as a dependent except for age,
   g. covered as a dependent on your Plan immediately prior to the child's 26th birthday, and
   h. not eligible for any other group health insurance benefits.
4. The above requirements must be met to be eligible for coverage as an incapacitated child. The SEIB shall decide whether an application for incapacitated status will be accepted and final approval of the incapacitation will be determined by Medical Review conducted by BCBS. 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 employed, the extent of his earning capacity will be evaluated.

See the “Enrolling an Incapacitated Child” section of the SEHIP plan book for critical enrollment deadlines. If deadlines are not met and/or continuous coverage is not maintained on the child, an Incapacitated Child over the age of 25 is not eligible for coverage.

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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