STATE EMPLOYEES' INSURANCE BOARD

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Phone: 334-263-8341 or 1-866-836-9737 • Fax: 334-263-8541
www.alseib.org

Faye Nelson
Chair

William L. Ashmore
CEO

RETIREE'S NAME: ____

RETIREE'S STREET ADDRESS: ____

RETIREE'S CITY, STATE, ZIP: ____

CONTRACT #: __________________________

RETIREMENT DATE: __________________________

Dear Retiree:

Act 2011-698 (SB309) changed the sliding scale calculations for employees retiring on and after January 1, 2012 as follows:

- Employees who retire after December 31, 2011 must have at least 10 years of creditable coverage and begin receiving a monthly retirement benefit from the RSA to be eligible to continue coverage under the State Employees' Health Insurance Plan (SEHIP).

- The employer contribution for employees who retire after December 31, 2011 is reduced by 4% for the years and months of creditable coverage less than 25 and increased by 2% for the years and months over 25.

- The employer contribution for employees who retire after December 31, 2011 is reduced by 1%, multiplied by the difference between Medicare entitlement age (currently 65) and the age of the employee at retirement. This applies until a retiree receives Medicare.

- Employees who retire on disability after December 31, 2011 and provide documentation to show they have applied for Social Security Disability are exempt from the sliding scale years of creditable coverage calculation for a period of 2 years and thereafter, if approved for Social Security Disability. Disability retirees after December 31, 2011 are not exempt from the sliding scale Medicare age calculation.

- Employees in DROP will not be subject to the new sliding scale calculation provided the participant does not voluntarily terminate DROP participation within the first 3 years and withdraws from service at the end of DROP. Employees that continue service after the end of DROP are subject to the new sliding scale calculations.

Years of creditable coverage is defined as the years and months that an employee is covered under the State Employees' Health Insurance Plan prior to retirement, as determined by the State Employees' Insurance Board. Creditable coverage shall also include: (1) military service credit purchased from the RSA, (2) part-time employment credit in the RSA prior to October 1, 2005, and (3) employment service credit when covered by PEEHIP.

Since we may not have a complete record of your years of creditable coverage, please complete the form on the back of this letter and return it to us within two weeks.

We greatly appreciate your assistance in this matter. If we can be of further service, please contact us at (334) 263-8341 or toll-free at (866) 836-9737.

The State Employees' Insurance Board complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-216-3144.
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-216-3144.

STATE EMPLOYEES' HEALTH INSURANCE PLAN (SEHIP)
YEARS OF CREDITABLE COVERAGE VERIFICATION FORM

Please provide the coverage periods that you were or have been enrolled in the SEHIP as a full-time employee:

From ______________________________ To ______________________________

If you have had breaks in your SEHIP coverage when you were not covered, please provide complete details of your coverage periods, including all gaps in coverage, on a separate sheet and attach it to this form.

Additional years and months of creditable coverage:

For military service credit purchased from the RSA ______________________________

Part-time employment credit in the RSA ______________________________

Employment credit covered by PEEHIP ______________________________

If you participated in DROP, please provide the dates of your DROP participation:

Entered DROP__________________ End of DROP______________________________

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 representations made by me on this form are true and complete. I understand that any misrepresentations may result in the forfeiture of insurance coverage and that I will be personally liable for all claims related to such misrepresentation, plus interest.

Retiree Signature__________________________________Date________________

Contract Number ____