Revised 10/09

STATE EMPLOYEE PLAN CHANGE FORM

☐ **SEHIP** (Blue Cross) Basic Medical

☐ * **Supplemental Coverage** (Blue Cross) Secondary Medical

☐ **Optional Policies** (Southland) Vision Dental Cancer Hospital Indemnity

SUBSCRIBER INFORMATION		
Name (First, Middle Initial, Last)	Sex:	Effective Date of Coverage _____/_____/_____
Social Security Number:	Date of Birth:	
Street Address:		
City	State	ZIP Code
Home Telephone Number: ( )	Work Telephone Number: ( ) Ext.	

First Name Middle Initial Last Name	(Documentation is only required for enrollment in SEHIP) Relationship to Employee	Birth Date	Social Security Number
	☐ Husband ☐ Wife		
	☐ Son ☐ Stepson ☐ Daughter ☐ Stepdaughter		
	☐ Son ☐ Stepson ☐ Daughter ☐ Stepdaughter		
	☐ Other Relationship		

IMPORTANT To be eligible for the non-tobacco and/or wellness discount, you must complete the Non-Tobacco User Discount Application form and the Wellness Discount form.

PRIMARY GROUP HEALTH INSURANCE COVERAGE INFORMATION

(Must be completed if choosing supplemental coverage or Southland.)

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

Is Dental Coverage Available? ☐ **Yes** ☐ **No**

If Yes, you are required to complete the information below.
If no, the State Employees' Health Insurance Plan Dental Coverage will serve as your primary dental coverage.

Dental Insurance Company	**Contract Holder**	**Insurance Policy #**	**Group #**	**Name of Employer**

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

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

** 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.