

STATE EMPLOYEES' HEALTH INSURANCE PROGRAM RETIREE HEALTH INSURANCE ENROLLMENT FORM

SEHIP (Blue Cross)

Blue Cross - Dental Only (Tri-Care for Life)

Supplemental Coverage (Blue Cross)
Secondary Medical

Optional Policies (Southland)
τ Vision τ Dental τ Cancer τ Hospital Indemnity

SUBSCRIBER INFORMATION

Name (First, Middle Initial, Last):			Sex:	
Social Security Number:		Date of Birth:		
Street Address:				
City:		County:	State:	Zip Code:
Home Telephone Number: ()			Work Telephone Number: ()	

Dependent Coverage is requested for the following individuals, effective on Month: _____ Day: _____ Year: _____. Direct payment MUST be made for premiums that will not be payroll deducted. Make check payable to the State Employees' Insurance Board and attach to this form.

First Name	Middle 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"/> Other Relationship		

IMPORTANT To be eligible for the non-tobacco user discount, you must submit documentation to the SEIB within 60 days of enrollment. Contact the SEIB about how to apply.

ADDITIONAL GROUP HEALTH INSURANCE COVERAGE

Medicare A Medicare B Other (specify) _____

ADDITIONAL GROUP HEALTH & DENTAL COVERAGE				
(Must be completed if choosing supplemental coverage, TRICARE for Life or Southland.)				
Health Insurance Company	Contract Holder	Insurance Policy #	Group #	Name of Employer
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.

RETURN TO:

STATE EMPLOYEES' INSURANCE BOARD
PO BOX 304900
MONTGOMERY, AL 36130-4900
334-263-8341 / 1-866-836-9737 / FAX: 334-263-8541

Member Signature/Date

Eligible Dependent

The term "dependent" includes the following individuals. Appropriate documentation (marriage certificate, birth certificate, court decree, etc.) required for SEHIP:

1. Employee's spouse (an ex-spouse cannot be covered).
2. An unmarried child under age 19, only if the child is:
 - a. employee's son or daughter
 - b. a child legally adopted by the employee (including any probationary period during which the child is required to live with the employee)
 - c. employee's stepchild
3. An unmarried grandchild, niece, or nephew, under age 19, only if:
 - a. the court has granted the employee custody, and
 - b. he/she is not eligible for other group health insurance.
4. Children age 19 through 25 who are full-time unmarried students attending an accredited institution. Annual student verification from the institution must be filed with the SEIB.
5. An incapacitated dependent will be considered for coverage to any age provided 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 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, employees should 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 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:
 - the employee's spouse loses the other coverage because:
 - a. spouse's employer ceases operations, or
 - b. spouse's loss of eligibility due to termination of employment or reduction of hours of employment, or
 - c. spouse's employer stopped contribution to coverage,
 - change form is submitted to the SEIB within 30 days of the incapacitated dependent's loss of other coverage, and
 - 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.**

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