Revised 02/2010

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: ( ) Ext.	

List covered dependents below.

First Name Middle Initial Last Name	Relationship to Employee	Birth Date	Social Security Number
	☐ Husband ☐ Wife		
	☐ Son ☐ Stepson ☐ Daughter ☐ Stepdaughter		
	☐ Son ☐ Stepson ☐ Daughter ☐ Stepdaughter		
	☐ Son ☐ Stepson ☐ Daughter ☐ Stepdaughter		

IMPORTANT: To be eligible for the non-tobacco discount, you must submit a Non-Tobacco User Discount Application form if you do not have one on file.

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

TO BE COMPLETED BY EMPLOYER

DATE STARTED TO WORK: _____

_____
Signature of Payroll Clerk Date

_____
State Agency

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