# TRICARE SUPPLEMENT ENROLLMENT FORM

Return completed form to:
State Employees' Insurance Board
201 South Union Street, Suite 200 • Post Office Box 304900
Montgomery, Alabama 36130-4900
Phone: (334) 263-8341 • Toll Free: 1-866-836-9737 • Fax: (334) 263-8541 Email: SEIBEnrollments@alseib.org • Web: www.alseib.org

## A. SUBSCRIBER INFORMATION

**First Name**_____ **M.I.**_____ **Last Name**_____

**SSN** _____

**Mailing Address**_____

_____
**City** **State** **ZIP Code**

Home Telephone # _____ Email Address_____

| Subscriber's Birth Date | Mo. | Day | Yr. | Gender |
|---|---|---|---|---|
| | | | | ☐M ☐F |

| Effective Date of Coverage | Mo. | Day | Yr. |
|---|---|---|---|
| | | **0 1** | |

## B. ENROLLMENT

### SelmanCo TRICARE Supplement

☐ Single

☐ Family [Children only] (complete Section C)

☐ Family [Spouse only] (complete Section C)

☐ Family [Spouse and Children] (complete Section C)

**NOTE:** If you do not currently have TRICARE coverage as a current or former military member, **SEIB cannot enroll you in TRICARE coverage**, and you are not eligible for the TRICARE Supplement Plan. In addition, you are not eligible for the TRICARE Supplement Plan if you are age 65 or older. If you currently have TRICARE coverage, you can choose to enroll in the TRICARE Supplement Plan. Electing to purchase the TRICARE Supplement Plan means that TRICARE will be primarily responsible for your medical coverage and the supplement plan will be secondarily responsible for coverage. The plan covers the cost shares and copays, including prescription drugs; most TRICARE plan deductibles; and excess charges up to the legal limit. By your election, you submit to the eligibility rules of TRICARE and the TRICARE Supplement Plan.

Last 4 SSN __ __ __ __

## C. Dependent Information - Attach Separate Sheet, if necessary

SPOUSE

Name _____
Date of Birth _____
SSN _____

☐ Male
☐ Female

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CHILD

Name _____
Date of Birth _____
Relationship to Subscriber _____

SSN _____
☐ Male
☐ Female

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CHILD

Name _____
Date of Birth _____
Relationship to Subscriber _____

SSN _____
☐ Male
☐ Female

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**AFFIRMATION AND RELEASE**
**Sign and Date for all chosen coverages**

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.

I understand and acknowledge that it is my responsibility to notify the SEIB immediately when the eligibility of a covered dependent changes. If it is determined that an act on my part (such as adding an ineligible person to coverage) or omission (such as failing to remove a person no longer eligible for coverage) results in or contributes to the payment of claims for persons ineligible for coverage, I will be personally responsible for all such over payments and shall be subject to disciplinary action, including termination of coverage.

Signature: _____ Date: _____