IB02

ACTIVE EMPLOYEE ENROLLMENT FORM

Rev. 12/22

A. Subscriber Information

Name (First, Middle Initial, Last):	Gender:	Social Security Number:	Date of Birth:

Physical Address:	City:	State:	ZIP Code:

Mailing Address (if different):	City:	State:	ZIP Code:

Home Phone Number:	Cell Phone Number:	Work Phone Number:	E-Mail Address:

Employee ID (if available):	State Agency:	Are you or your spouse eligible for other group health insurance through a spouse, other employer, or previous employer? ☐ Yes ☐ No

B. Enrollment

Health Coverage – Choose one health plan/option or decline all health coverage:

- ☐ SEHIP Medical (administered by BCBS)
  - ☐ Single
  - ☐ Family (complete Section C)
- ☐ Supplemental Plan (complete Section D)
  - ☐ Single
  - ☐ Family (complete Section C)
- ☐ Optional Plan (complete Section D)
  - ☐ Single
  - ☐ Family (complete Section C)
- ☐ Premium Cash Option (complete Section D)
- ☐ Limited-Purpose HRA (complete Section D)
- ☐ Decline All Health Coverage

Stand-alone Dental Coverage – A minimum enrollment of 12 months is required.

Choose one dental plan or decline dental coverage by leaving the boxes empty:

- ☐ BCBS Dental Plan
  - ☐ Single $8 per month
  - ☐ Family $15 per month (complete Section C)
- ☐ Southland Dental Plan
  - ☐ Single $8 per month
  - ☐ Family $15 per month (complete Section C)

If no selection is made, the SEIB will not add dental coverage.

Other stand-alone policies – A minimum enrollment of 12 months is required for the Southland Cancer and Southland Vision policies.

Choose one or both policies or decline coverage by leaving the boxes empty:

- ☐ Southland Cancer Policy
  - ☐ Single $12 per month
  - ☐ Family $24 per month (complete Section C)
- ☐ Southland Vision Policy
  - ☐ Single $12 per month
  - ☐ Family $24 per month (complete Section C)

If no selection is made, the SEIB will not add cancer or vision coverage.

C. Dependent Information - Attach Separate Sheet, If Necessary

Coverage is requested to be effective on: Month_____ Day_____ Year_____

Coverage**
(Please check appropriate box to add dependent to coverage)

First Name Middle Initial Last Name	Relationship to Employee*	Gender	Date of Birth	Social Security Number	Add to Health	Add to Dental	Add to Cancer	Add to Vision
					☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐

* Documentation of relationship to employee is required for all plans except the Supplemental Plan (e.g., social security number, marriage certificate, birth certificate, court decree).

** Health means the health coverage chosen in Section B above. Dental means the stand-alone dental coverage chosen in Section B above. Cancer and Vision mean the stand-alone Southland Cancer or Southland Vision policies chosen in Section B above. If you did not choose a health, dental, cancer, or vision plan in Section B, leave that coverage box empty.

IMPORTANT: To be eligible for the wellness discount, you must meet the requirements of the Wellness Program. When adding a spouse to SEHIP coverage, a spousal surcharge of $50 per month will be applied. To receive a discount, you must submit a completed Spousal Surcharge Waiver Application (IB25). Forms are available at www.alseib.org.

Direct payment MUST be made for any premiums that will not be payroll deducted.

D. Other Insurance Information

Are you, your spouse, or dependent(s) covered under any other group health insurance? ☐ Yes* ☐ No

*If you answered yes, you must complete the Other Group Health Insurance Addendum on Page 3.

PREMIUM CASH OPTION (PCO) DISCLOSURE
Sign and Date only if enrolling in the PCO

Important – Read Carefully Before Signing

The PCO is intended to qualify as a "health reimbursement arrangement" as that term is defined under IRS Notice 2002-45 and 2013-54 and a medical reimbursement plan under Sections 105 and 106 of the Internal Revenue Code of 1986, as amended, and the Plan will be interpreted at all times in a manner consistent with such intent. I understand that I will only seek reimbursement for premiums for health insurance coverage that qualify for such reimbursement under IRS regulations. I hereby certify that I have completely read and fully understand the terms and conditions of the PCO and all information furnished is true and complete.

Employee Signature:_____ Date: _____

LIMITED-PURPOSE HRA (LPHRA) DISCLOSURE
Sign and Date only if enrolling in the LPHRA

Important – Read Carefully Before Signing

The LPHRA is intended to qualify as a "health reimbursement arrangement" as that term is defined under IRS Notice 2002-45 and 2013-54 and a medical reimbursement plan under Sections 105 and 106 of the Internal Revenue Code of 1986, as amended, and the Plan will be interpreted at all times in a manner consistent with such intent. I understand that I will only seek reimbursement for dental or vision expenses that qualify for such reimbursement under IRS regulations. I hereby certify that I have completely read and fully understand the terms and conditions of the LPHRA and all information furnished is true and complete.

Employee Signature:_____ Date: _____

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 overpayments and shall be subject to disciplinary action, including termination of coverage.

Employee Signature:_____ Date: _____

If any of the following advisors assisted you, check the box by their name:

☑ Genie Blake ☐ Michelle Dallas

TO BE COMPLETED BY EMPLOYER

EMPLOYMENT STATUS:	PAY FREQUENCY:
☐ Full Time ☐ 3/4 Time ☐ 1/2 Time ☐ 1/4 Time	☐ Semi-Monthly Arrears ☐ Semi-Monthly Current ☐ Monthly
EMPLOYEE'S EFFECTIVE DATE OF COVERAGE:	EMPLOYEE'S HIRE DATE:

Payroll Clerk Name:_____ Employee's County of Employment:_____

Payroll Clerk Signature:_____ State Agency Code:_____ Date: _____

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
SEIBEnrollments@alseib.org
www.alseib.org

Other Group Health Insurance Addendum

Must be completed if choosing the Supplemental Plan, Optional Plan, Premium Cash Option, Limited Purpose HRA or if you, your spouse and/or dependents have any other coverage, excluding Medicare and other coverage through the SEIB.

LIST EACH INSURANCE COMPANY SEPARATELY (ATTACH ADDITIONAL SHEETS IF NECESSARY)			
Name of Contract Holder	Contract Holder Date of Birth	Group #	Insurance Contract #
Name of Insurance Company		Types of coverage (Check all that apply) ☐ Hospitalization ☐ Doctor's Visits ☐ Prescription Drugs ☐ Dental	
Name of Employer			
Are you or any of your dependents covered on this insurance policy? ☐ Yes (list each covered individual below) ☐ No			
Name(s) (First, Middle Name, Last)	Date of Birth	Coverage Effective Date(s)	

LIST EACH INSURANCE COMPANY SEPARATELY (ATTACH ADDITIONAL SHEETS IF NECESSARY)			
Name of Contract Holder	Contract Holder Date of Birth	Group #	Insurance Contract #
Name of Insurance Company		Types of coverage (Check all that apply) ☐ Hospitalization ☐ Doctor's Visits ☐ Prescription Drugs ☐ Dental	
Name of Employer			
Are you or any of your dependents covered on this insurance policy? ☐ Yes (list each covered individual below) ☐ No			
Name(s) (First, Middle Name, Last)	Date of Birth	Coverage Effective Date(s)	

COVERAGE OPTIONS

Health Plans available to state employees who are eligible for Other Group Health Insurance (OGHI) through a spouse, other employer or previous employer:

Supplemental Plan

The State Employees' Supplemental Coverage Plan (Supplemental Plan) is administered by Blue Cross Blue Shield of Alabama. Members enrolled in the Supplemental Plan can return to the State Employees' Health Insurance Plan (SEHIP) on the first day of any month:

- The Supplemental Plan is free for you and your eligible dependents.
- The Supplemental Plan pays for copays and/or deductibles that your primary OGHI does not cover 100%.
- Members enrolled in the Supplemental Plan can enroll in or continue dental, vision, and/or cancer coverage with the SEIB.

You may not enroll in the Supplemental Plan if your OGHI is with the State Employees' Health Insurance Plan (SEHIP), Public Education Employees Health Insurance Program (PEEHIP), Local Government Health Insurance Program (LGHIP), the Marketplace, TRICARE, Medicaid or Medicare. Also, OGHI plans with an in-network deductible higher than $1,350 for individual or $2,700 for family coverage are not eligible.

For more information, contact your SEIB Benefits Advisor or see the State Employees' Supplemental Coverage Plan handbook at www.alseib.org.

Optional Plan

The State Employees' Insurance Board Optional Insurance Plan (Optional Plan), administered by Southland Benefit Solutions, offers you four coverages in one. This option is free and provides the following benefits:

- The Optional Plan provides dental, vision, hospital indemnity, and cancer coverage, all in one.
- The dental benefits included in the Optional Plan include an extensive provider network with enhanced benefits.

You may not enroll in the Optional Plan if your OGHI is with the SEHIP or Medicaid. If you are an active employee and your primary coverage is TRICARE, you are not eligible for the Optional Plan. Employees who decline coverage in the SEHIP and enroll in the Optional Plan may not enroll in the Supplemental Plan, Dental Plan, Vision Policy, Cancer Policy or PCO.

For more information, contact your SEIB Benefits Advisor or see the SEIB Optional Insurance Plan handbook at www.alseib.org**.**

Premium Cash Option

The Premium Cash Option (PCO), administered by Optum Financial, helps offset premiums you incur through OGHI:

- Must be an active, full-time state employee.
- PCO reimbursement is up to $175 per month to offset your OGHI premium.
- The monthly reimbursement can be mailed directly to you or direct deposited into a savings or checking account.

If your monthly premium is less than $175, the remaining balance is placed in your account for later use. You may not enroll in the PCO if your OGHI is with the SEHIP, the Marketplace, Medicaid or Medicare.

For more information, contact your SEIB Benefits Advisor or see the Premium Cash Option handbook at www.alseib.org.

Limited-Purpose HRA

The Limited-Purpose HRA, administered by Optum Financial, provides $175 per month for eligible dental and vision expenses. This plan is ideal for those with other group (employer plans) or non-group (individual or governmental plans) health insurance coverage besides SEHIP (BCBS #13000) or other free plans offered by the SEIB.

Funds not used for dental or vision expenses will continue to accumulate in the account for future use.

For more details, please review the contact your SEIB Benefits Advisor or see the Limited-Purpose HRA handbook at www.alseib.org.

Health Plan available to state employees who are <u>not</u> eligible for Other Group Health Insurance (OGHI) through a spouse, other employer or previous employer:

State Employees' Health Insurance Plan

The State Employees' Health Insurance Plan (SEHIP), administered by Blue Cross Blue Shield of Alabama, is typically the plan state employees choose when they do not have OGHI coverage available through a spouse, other employer or previous employer. Members who choose this option:

- Pay a monthly premium.
- Pay copays and/or deductibles for health and pharmacy services.
- May be subject to wellness premiums, premiums for tobacco use and may be subject to a premium for adding a spouse as a dependent.

For more information, see the State Employees' Health Insurance Plan handbook at www.alseib.org.

Decline Health Coverage

State employees also have the option to decline all health benefit options offered through the SEIB. Employees who decline health coverage may apply for health coverage during annual open enrollment or as otherwise specified in the SEHIP handbook. The Affordable Care Act requires each individual to have basic health insurance coverage (known as minimum essential coverage), qualify for an exemption, or make a shared responsibility payment when filing his/her federal income tax return. Failure to enroll in the SEHIP or obtain other minimum essential coverage may result in personal financial penalties.

Stand-alone Dental Plans available to state employees:

BCBS Dental Plan (administered by BCBS)

Blue Cross Blue Shield of Alabama's (BCBS) Dental Network includes more than 1,750 dentists, approximately 89% of the dentists in Alabama. This managed care program provides diagnostic and preventive services covered at 100% of the preferred dental fee schedule with no deductible. It also provides basic and major services, including fillings, oral surgery, periodontics, endodontics, prosthodontics, and orthodontic services, subject to deductibles, co-pays, and an annual maximum benefit.

For more information, see the BCBS Dental Benefit Summary and the State Employees' Dental Insurance Plan handbook at www.alseib.org.

Southland Dental Plan (administered by Southland Benefit Solutions)

Note: The Southland Dental Plan is included in the free Optional Plan mentioned above, but, as a stand-alone policy, you must pay a premium.

Southland Benefit Solutions (Southland) provides a dental program with one of the largest dental networks in the State of Alabama. It is comparable in design to the BCBS Dental Plan with some differences in deductibles, co-pays, and maximum benefits available. It does not provide orthodontic benefits. For more information, see the State Employees' Southland Dental Plan handbook at www.alseib.org.

Other stand-alone policies available to state employees. Note: These policies are included in the free Optional Plan mentioned above, but, as stand-alone policies, you must pay a premium:

Southland Cancer Policy

This policy helps offset the out-of-pocket costs you may incur with a qualifying cancer diagnosis. The policy pays a specified benefit for the following: hospital confinement, anesthesia, hospice care, ambulance, blood and plasma, nursing services, attending physician, prosthetic devices, radiation and chemotherapy, surgical procedures (payment varies depending on diagnosis). For costs and details of coverage, review the SEIB Cancer Policy handbook at www.alseib.org.

Southland Vision Policy

This policy helps offset the out-of-pocket costs associated with eye examinations, prescription lenses or contacts, and eyeglass frames. There is no network requirement, so you may utilize any eye care provider. The policy is subject to maximum benefits. For costs and details of coverage, review the SEIB Vision Policy handbook at www.alseib.org.

GENERAL INFORMATION

Eligible Dependent
(Appropriate documentation must be attached.)
The term "dependent" includes the following individuals, subject to appropriate documentation (Social Security number, marriage certificate, birth certificate, court decree, etc.):

- Your spouse (excludes divorced or common-law spouse);
- A child under age 26, only if the child is:
  - your son or daughter,
  - legally adopted by you or your spouse,
  - your stepchild, or
  - a dependent for whom you, or your spouse, has legal and physical custody granted by a court of competent jurisdiction.
- Your incapacitated dependent child* over age 25 will be considered for coverage provided the dependent is:
  - unmarried,
  - permanently mentally or physically disabled or incapacitated,
  - had the condition prior to the dependent's 26th birthday,
  - incapable of self-sustaining employment,
  - dependent on you for 50% or more financial support,
  - otherwise eligible for coverage as a dependent except for age,
  - covered as a dependent on your Plan immediately prior to the child's 26th birthday, and
  - not eligible for any other group health insurance benefits.

*The above requirements must be met to be eligible for coverage as an incapacitated child. The SEIB shall decide whether an application for incapacitated status will be accepted and final approval of incapacitation will be determined by Medical Review conducted by BCBS. The SEIB reserves the right to periodically recertify incapacitation. Neither a reduction in work capacity nor the inability to find employment is, of itself, evidence of eligibility. If a mentally or physically incapacitated child is employed, the extent of their earning capacity will be evaluated.

Ineligible Dependents

- Your spouse or other dependents if they are independently covered as a state employee unless they are employed as a professional civil engineer trainee with ALDOT and their employment is part of their educational training
- An ex-spouse, regardless of what the divorce decree may state
- Ex-stepchildren, regardless of what the divorce decree may state
- Your biological child if the child has been adopted by someone other than your spouse and you have been relieved of your parental rights and responsibilities
- Children age 26 and older
- Incapacitated children age 26 and older who do not meet the Incapacitated Child eligibility requirements listed above under Eligible Dependent
- A child of a dependent child
- A daughter-in-law or son-in-law
- Grandchildren or other children related to the member by blood or marriage for which the member does not have legal and physical custody
- Grandparents
- Parents
- A fiancé or live-in girlfriend or boyfriend

Enrolling an Incapacitated Child

If your child is (1) incapacitated, (2) covered as a dependent on your Plan immediately prior to the child's 26th birthday, and (3) meets the other eligibility requirements listed above under Eligible Dependent, you must contact the SEIB to obtain an Incapacitated Child Certification form. A completed Incapacitated Child Certification form and proof of incapacity must be provided to the SEIB no more than 60 days after the child's 26th birthday. If you fail to submit the form and proof of incapacity within the required time period, or, if you do not maintain continuous coverage on the incapacitated child thereafter, your child is not eligible for future enrollment except in the following two situations:

- When a new employee requests coverage for an incapacitated child within 60 days of employment; or
- When an employee's incapacitated child is covered under a spouse's employer group health insurance for <u>at least 18 consecutive months</u> and:
  - the employee's spouse loses the other coverage because:
    - employer ceases operations, or
    - loss of eligibility due to termination of employment or reduction of hours of employment, or
    - employer stopped contributing to coverage,
  - a change form is submitted to the SEIB within 30 days of the incapacitated child's loss of other coverage, and
  - Medical Review approved incapacitation status.