

A. Subscriber Information			
Name (First, Middle Initial, Last):		Gender:	Social Security Number:
Physical Address:		City:	State:
Mailing Address (if different):		City:	State:
Home Phone Number:	Cell Phone Number:	Work Phone Number:	E-Mail Address:
Effective Date of Coverage:	Are you or your spouse eligible for other group health insurance through a spouse, other employer, or previous employer? <input type="checkbox"/> Yes <input type="checkbox"/> No		

B. Enrollment		
<p><b>Health Coverage – Choose <u>one</u> health plan/option or decline all health coverage:</b></p> <p><input type="checkbox"/> SEHIP Medical (administered by BCBS)</p> <p style="margin-left: 20px;"><input type="checkbox"/> Single <input type="checkbox"/> Family (complete section C)</p> <p><input type="checkbox"/> Medicare Advantage (Medicare Only)</p> <p style="margin-left: 20px;"><input type="checkbox"/> Single <input type="checkbox"/> Family (complete section C)</p> <p><input type="checkbox"/> Supplemental Plan (complete section E)</p> <p style="margin-left: 20px;"><input type="checkbox"/> Single <input type="checkbox"/> Family (complete section C)</p> <p><input type="checkbox"/> Optional Plan (complete section E)</p> <p style="margin-left: 20px;"><input type="checkbox"/> Single <input type="checkbox"/> Family (complete section C)</p> <p><input type="checkbox"/> Premium Cash Option (complete Section E) (active employees only)</p> <p><input type="checkbox"/> Limited-Purpose HRA (complete Section E) (active employees only)</p> <p><input type="checkbox"/> Decline All Health Coverage</p>	<p><b>Stand-alone Dental Coverage – A minimum enrollment of 12 months is required.</b></p> <p><b>Choose one dental plan or decline dental coverage by leaving the boxes empty:</b></p> <p><input type="checkbox"/> BCBS Dental Plan*</p> <p style="margin-left: 20px;"><input type="checkbox"/> Single \$8 per month <input type="checkbox"/> Family \$15 per month (complete section C)</p> <p><input type="checkbox"/> Southland Dental Plan*</p> <p style="margin-left: 20px;"><input type="checkbox"/> Single \$8 per month <input type="checkbox"/> Family \$15 per month (complete section C)</p> <p>If no selection is made, the SEIB will not add dental coverage.</p>	<p><b>Other stand-alone policies – A minimum enrollment of 12 months is required for the Southland Cancer and Southland Vision policies.</b></p> <p><b>Choose one or both policies or decline coverage by leaving the boxes empty:</b></p> <p><input type="checkbox"/> Southland Cancer Policy*</p> <p style="margin-left: 20px;"><input type="checkbox"/> Single \$12 per month <input type="checkbox"/> Family \$24 per month (complete section C)</p> <p><input type="checkbox"/> Southland Vision Policy*</p> <p style="margin-left: 20px;"><input type="checkbox"/> Single \$12 per month <input type="checkbox"/> Family \$24 per month (complete section C)</p> <p>If no selection is made, the SEIB will not add cancer or vision coverage.</p>

C. Dependent Information- Attach Separate Sheet, if necessary							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
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

\* 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 plan chosen in Section B, above. Dental means the stand-alone dental plan 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.elseib.org](http://www.elseib.org).

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

### D. Additional Coverage

Medicare Part A

Medicare Part B

Other (specify):

### E. Primary Insurance Information

(must be completed if choosing the Supplemental Plan, Optional Plan, or Premium Cash Option)

Health Insurance Company	Contract Holder	Insurance Policy #	Group #	Name of Employer
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Certain restrictions apply to high deductible health plans. A summary plan description of the other coverage must be provided to document the deductible amount. In addition, please note the Supplemental Plan does not coordinate with the Premium Cash Option.

If choosing the Supplemental Plan, you cannot maintain your primary coverage through the SEHIP, Local Government Health Insurance Plan, Public Education Employees' Health Insurance Plan, TRICARE, Medicaid, Medicare or the Marketplace.

For Supplemental Plan participants, you may need to manually file claims with BCBS for pharmacy benefit reimbursements as BCBS may not coordinate with your primary insurance carrier.

#### PREMIUM CASH OPTION (PCO) DISCLOSURE – Active Employees Only 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.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

Genie Blake     Michelle Dallas     Kerry Schlenker