PEEHIP_NESC
7/18

NEW ENROLLMENT AND STATUS CHANGE

Public Education Employees' Health Insurance Plan
P. O. Box 302150 ♦ Montgomery, Alabama 36130-2150
334.517.7000 or 877.517.0020
You may submit information online at **https://mso.rsa-al.gov**

Check One:
☐ Active Member
☐ Retired Member

PEEHIP Subscriber Information

Name must be entered as shown on your Social Security card.

Social Security Number	First Name	Middle Initial	Last Name	Date of Birth	Sex
					☐ M ☐ F

Marital Status
☐ Individual ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed

Date Married:

Mailing Address	City	State	ZIP Code

Is this a change of address?	Home Phone	Cell Phone	Work Phone
☐ Yes ☐ No			

Employer/School System	Date of Employment	Email Address

Have you or your spouse used tobacco products or an electronic smoking device within the last 12 months?* ****This information is required for enrollment.***

Member ☐ Yes ☐ No
Spouse ☐ Yes ☐ No

PEEHIP Coverage Information

(You will be billed for prorata premiums or premiums that are not deducted from your payroll or retirement check.)

Section A. New Enrollment

Hospital Medical *(PEEHIP plans are administered by Blue Cross and Blue Shield of AL)*	**Optional Coverage Plans** (*administered by Southland Benefit Solutions)*
Coverage Type: (*Select only one of the three plans*) ☐ PEEHIP Hospital Medical* **Administered by UnitedHealthCare for Medicare-eligible retirees and Medicare-eligible dependents of retirees.* ☐ VIVA Health Plan (HMO) ☐ PEEHIP Supplemental Medical (*Secondary Medical) Complete Section D* ☐ Individual or ☐ Family *(complete Section C)*	***Note:*** *Optional plans must be all Individual or all Family* Coverage Type(s): ☐ Cancer ☐ Dental ☐ Indemnity ☐ Vision ☐ Individual or ☐ Family *(complete Section C)* *These plans must be retained for one year until the following October 1. PEEHIP will not automatically cancel any coverage(s).*
Requested Effective Date (required) _____	**Requested Effective Date (required)** _____

Section B. PEEHIP Coverage Information (Only check boxes requiring a change to **existing** coverage.)

Coverage Type:	**PEEHIP Hosp. Med.**	****PEEHIP Supplemental**	**VIVA HMO**	**Cancer**	**Dental**	**Indemnity**	**Vision**
Change from Individual to **Family** Coverage	☐	☐	☐	☐	☐	☐	☐
Add dependent(s) listed in Section C to Family Coverage	☐	☐	☐	☐	☐	☐	☐
Cancel Coverage	☐	☐	☐	☐	☐	☐	☐
Change from Family to **Individual** Coverage	☐	☐	☐	☐	☐	☐	☐
Cancel dependent(s) listed in Section C from Family Coverage	☐	☐	☐	☐	☐	☐	☐

Requested Effective Date
(required) QLE changes must be submitted within 45 days of the QLE. _____

Reason for Status Change(s) *(check all that apply)*
Changes cannot be processed without the appropriate documentation as explained in the Member Handbook for starred (*) items.

Date change occurred ***(required)*** _____

☐ Open Enrollment – **Change effective October 1st**
☐ Adoption of a child* *(adoption papers)*
☐ Birth of a child* *(birth certificate)*
☐ Death of spouse/dependent* *(death certificate)*
☐ Loss of eligibility for other coverage* *(proof of loss of coverage)*
☐ Divorce/Annulment/Legal Separation* *(divorce decree)*
☐ FMLA/LOA
☐ Medicare/Medicaid entitlement* *(copy of card to cancel coverage)*
☐ Legal custody of a child* *(legal custody papers)*
☐ Marriage* *(marriage certificate & add'l proof of marriage)*
☐ Marriage of dependent child* *(marriage certificate)*
☐ Termination of member/spouse/dependent employment*
☐ Commencement of spouse/dependent employment*
☐ Enrolling in PEEHIP Supplemental Medical Plan
☐ Spouse's employer with different open enrollment period* *(to cancel Hospital Medical coverage only)*

Note: Active members must have an IRS qualifying life event (QLE) to cancel their Hospital Medical or change their coverage outside of Open Enrollment because their premiums are pre-taxed. ***QLE changes must be submitted within 45 days of the QLE.***

Section C. Dependent Information *(only required for family coverage)*

Social Security Number is required for all dependents. Name must be entered as it appears on the Social Security card. Appropriate eligibility documents are required for all dependents: All children – birth certificates; spouses – marriage certificate & additional current marriage document; adopted children – certificate of adoption or papers from adoption agency showing intent to adopt; step children – also required is the marriage certificate showing member's spouse is married to member; foster and other children – also required is the placement authorization signed by a judge or final court order with judge's signature and seal. *(See handbook for more detail.)*

Name of Dependent *(First, Middle, Last)*	Social Security #	Date of Birth	Relation to Subscriber	Sex	Handicapped
			☐ Spouse	☐ M ☐ F	N/A
			☐ Biological ☐ Adopted ☐ Step ☐ Other	☐ M ☐ F	☐ Yes ☐ No
			☐ Biological ☐ Adopted ☐ Step ☐ Other	☐ M ☐ F	☐ Yes ☐ No
			☐ Biological ☐ Adopted ☐ Step ☐ Other	☐ M ☐ F	☐ Yes ☐ No
			☐ Biological ☐ Adopted ☐ Step ☐ Other	☐ M ☐ F	☐ Yes ☐ No
			☐ Biological ☐ Adopted ☐ Step ☐ Other	☐ M ☐ F	☐ Yes ☐ No

Section D. Primary Insurance Information** *(Must be completed if choosing PEEHIP Supplemental Medical)*

Name of Insurance Company	Phone Number	Contract/Policy #	Effective Date of Coverage

Section E. Additional (Non-PEEHIP) Health Insurance Coverage Information *(Must be completed for enrollment)*

Are you, your spouse, or dependent children covered under any other Hospital, Medical, Dental, or Vision plan(s)? ☐ Yes* ☐ No

*If you answered yes, you must complete a separate COORDINATION OF BENEFITS (COB) form, available at www.rsa-al.gov.

Section F. Retiree Other Employer Information *(Must be completed if you retired after September 30, 2005)*

Are you a retiree and employed by another employer? ☐ Yes* ☐ No

*If you answered yes and you retired after September 30, 2005, and became employed by another employer, you must complete a separate RETIREE EMPLOYMENT VERIFICATION form available at www.rsa-al.gov.

Section G. Medicare Information *(Must be completed if you or your dependents are eligible for Medicare)*

Are you or your covered dependent(s) eligible for Medicare? ☐ Yes* ☐ No

*If you answered yes, you must complete this section and provide a copy of the Medicare card(s) to PEEHIP before your monthly retiree premium can be reduced. **Note: As a retiree or a dependent on a retired account, you MUST have BOTH Part A and Part B to have coverage with PEEHIP.** If you do not have both Part A & Part B, you will not be eligible for PEEHIP's Medicare Advantage plan and will not have Hospital Medical or prescription drug coverage with PEEHIP.

Name	Medicare Card Number

Check the Medicare Part(s) for which you are eligible:

☐ Part A-Effective: ☐ Part B-Effective: ☐ Part D**-Effective:

Name	Medicare Card Number

Check the Medicare Part(s) for which you are eligible:

☐ Part A-Effective: ☐ Part B-Effective: ☐ Part D**-Effective:

***If you are enrolled in another Medicare Part D plan (other than PEEHIP's group Part D plan), you are not eligible for the PEEHIP prescription drug plan coverage.*

Section H. PEEHIP Subscriber Certification

Under penalties of perjury, I declare that I have examined this form and statements, and to the best of my knowledge and belief, they are true and correct. I further understand that there is mandatory utilization review, and I do hereby release any information necessary to evaluate, administer and process claims for benefits to any person, entity or representative acting on the Plan's behalf. I also agree to periodic tobacco usage testing and agree to notify the PEEHIP office if my or my spouse's tobacco status changes or if my employment status changes. I also agree to have premiums deducted from my retirement check or paycheck for any prior months that are due but were not deducted at the proper time.

Member Signature **Date Signed**

Please mail the completed form to the address located on the front of this form.