STATE EMPLOYEES' HEALTH INSURANCE PROGRAM
RETIREE HEALTH INSURANCE ENROLLMENT FORM

☐ **SEHIP** (Blue Cross)

☐ **Blue Cross - Dental Only** (Tri-Care for Life**)**

☐ **Supplemental Coverage** (Blue Cross)
Secondary Medical

☐ **Optional Policies** (Southland)
Vision Dental Cancer Hospital Indemnity

SUBSCRIBER INFORMATION

Name (First, Middle Initial, Last):			**Sex:**
Social Security Number:		**Date of Birth:**	
Street Address:			
City:	**County:**	**State:**	**Zip Code:**
Home Telephone Number:		**Work Telephone Number:**	

Dependent Coverage is requested for the following individuals, effective on Month: _____Day: _____ Year: _____. Direct payment MUST be made for premiums that will not be payroll deducted. Make check payable to the State Employees' Insurance Board and attach to this form.

First Name Middle Initial Last Name	**Documentation is required. See back of form. Relationship to Employee**		**Date of Birth**	**Social Security Number**
	☐ **Husband**	☐ **Wife**		
	☐ **Son** ☐ **Stepson**	☐ **Daughter** ☐ **Stepdaughter**		
	☐ **Son** ☐ **Stepson**	☐ **Daughter** ☐ **Stepdaughter**		
	☐ **Other Relationship**			

IMPORTANT To be eligible for the non-tobacco user discount, you must submit documentation to the SEIB within 60 days of enrollment. Contact the SEIB about how to apply.

ADDITIONAL GROUP HEALTH INSURANCE COVERAGE

☐ **Medicare A** ☐ **Medicare B** ☐ **Other (specify)** _____

ADDITIONAL GROUP HEALTH & DENTAL COVERAGE
(Must be completed if choosing supplemental coverage, TRICARE for Life or Southland.)

Health Insurance Company	**Contract Holder**	**Insurance Policy #**	**Group #**	**Name of Employer**
Dental Insurance Company	**Contract Holder**	**Insurance Policy #**	**Group #**	**Name of Employer**

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.

_____
Member Signature/Date

RETURN TO:

STATE EMPLOYEES' INSURANCE BOARD
PO BOX 304900
MONTGOMERY, AL 36130-4900
334-263-8341 / 1-866-836-9737 / FAX: 334-517-9728

State Employees' Health Insurance Plan

Eligible Dependent

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

1. Your spouse (excludes divorced or common-law spouse).
2. A child under age 26, only if the child is:
   a. your son or daughter,
   b. a child legally adopted by you or your spouse (including any probationary period during which the child is required to live with you),
   c. your stepchild,
   d. your grandchild, niece, or nephew for whom the court has granted custody to you or your spouse.

(Exception: children age 19 and older who are eligible for coverage through their employer are not eligible for coverage under SEHIP.)

3. An incapacitated dependent over age 25 will be considered for coverage provided dependent:
   a. is unmarried,
   b. is permanently mentally or physically disabled or incapacitated,
   c. is so incapacitated as to be incapable of self-sustaining employment,
   d. is dependent on you for 50% or more support,
   e. is otherwise eligible for coverage as a dependent except for age,
   f. the condition must have occurred prior to the dependent's 26th birthday, and
   g. is not eligible for any other group health insurance benefits.

Neither a reduction in work capacity nor inability to find employment is, of itself, evidence of eligibility. If a mentally or physically disabled dependent is working, despite his disability, the extent of his earning capacity will be evaluated.

To apply, contact the SEIB to obtain an Incapacitated Dependent Certification Form. Final approval of incapacitation will be determined by Medical Review. Proof of disability must be provided to the SEIB within 60 days from the date the child would cease to be covered because of age.

Exception: There are two situations under which it may be possible to add an incapacitated dependent who otherwise meets the eligibility requirements except for age:

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

The above requirements must be met as a minimum threshold in order to be considered for incapacitation status. The SEIB shall make the final decision as to whether an application for incapacitated status will be accepted. NOTE: The SEIB reserves the right to periodically re-certify incapacitation.

In the event of the death of an active employee, who carried family coverage, the eligible dependents may continue coverage by making the appropriate premium payment to the SEIB. The SEIB must be notified within 90 days of the death.

Exclusion: You may not cover your wife, husband, or other dependents if they are independently covered as a State employee.