IB02

HEALTH INSURANCE ENROLLMENT FORM

Revised 08/12

☐ **SEHIP** (Blue Cross) Basic Medical ☐ **Supplemental Coverage** (Blue Cross) Secondary Medical ☐ **Optional Policies** (Southland) Vision / Dental / Cancer / Hospital Indemnity

☐ **Decline Coverage**

SUBSCRIBER INFORMATION

Name (First, Middle Initial, Last)		Sex:
Social Security Number:	Date of Birth:	
Street Address:		
City	State	ZIP Code
Home Telephone Number:	Work Telephone Number:	E-Mail Address:

Dependent Coverage is requested for the following individuals, effective on Month _____Day _____ Year_____. Direct payment MUST be made for any premiums that will not be payroll deducted. Make check payable to the SEIB and attach to this form.

First Name Middle Initial Last Name	Documentation is required. 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 and/or wellness discount, you must complete the Non-Tobacco User Discount Application and meet the requirements of the Wellness Program.

ADDITIONAL GROUP HEALTH INSURANCE COVERAGE INFORMATION

(Must be completed if choosing supplemental coverage or Southland.)

Does the ***primary coverage*** have a spousal carve-out? ☐ Yes? ☐ No?

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

Is Dental Coverage Available? ☐ **Yes** ☐ **No**

If Yes, you are required to complete the information below.

If no, the State Employees' Health Insurance Plan Dental Coverage will serve as your primary dental coverage.

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

TO BE COMPLETED BY EMPLOYER

1. EMPLOYMENT STATUS:
   ☐ Full Time ☐ 3/4 Time ☐ ½ Time ☐ 1/4 Time
2. EMPLOYEE'S EFFECTIVE DATE OF COVERAGE: _____
3. PAY FREQUENCY: ☐ Semi-Monthly Arrears
   ☐ Semi-Monthly Current ☐ Monthly

_____
Signature of Payroll Clerk Date

_____
State Agency

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.

_____ _____
Employee Signature Date

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.

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