PEEHIP Change (06/12)
50

Check One:
☐ Active Member
☐ Retired Member

HEALTH INSURANCE AND OPTIONAL STATUS CHANGE

Public Education Employees' Health Insurance Plan
P. O. Box 302150 ♦ Montgomery, Alabama 36130-2150
334-517-7000 or 877-517-0020
Web site: www.rsa-al.gov

This form is to be used to make changes to your existing insurance coverages and to certify or change your tobacco status.
In lieu of completing and mailing this form, you can make your changes online using the Web site above.
Please print and complete the front and back of form.

PEEHIP Subscriber Information

Name must be entered as shown on Social Security card. ***All address changes must be made online or on the RSA Address Change Notification.***

Social Security Number or PID Number	First Name	Middle Name/Initial	Last Name

Date of Birth	Daytime Phone	Marital Status
_____/_____/_____	_____-_____-_____	☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed

Have you or your spouse used tobacco products within the last 12 months?* Member ☐ Yes ☐ No Spouse ☐ Yes ☐ No

This information is required for enrollment.

Please complete the following fields if you have changed your name or changed employers.

Previous Full Name *(First, MI, Last)* / Previous School System	New Full Name *(First, MI, Last)* / New School System	Date of Employment Transfer
		_____/_____/_____

PEEHIP Coverage Information

For an effective date of coverage other than October 1, there is a 270 day waiting period for pre-existing conditions for dependents age 19 and over unless proof of previous coverage is received and approved by the PEEHIP office. The PEEHIP office will not automatically cancel any coverage(s).
All cancellations must be indicated on the Health Insurance Status Change form.

Coverage Type: (Only check boxes requiring a change)	PEEHIP Hosp/Med	PEEHIP Supplemental **	VIVA HMO	Cancer	Dental	Indemnity	Vision
				(Optional plans must be all Single or all Family)			
Change from Single to **Family** Coverage	☐	☐	☐	☐	☐	☐	☐
Add dependent(s) listed below to Family Coverage	☐	☐	☐	☐	☐	☐	☐
Cancel Coverage	☐	☐	☐	☐	☐	☐	☐
Change from Family to **Single** Coverage	☐	☐	☐	☐	☐	☐	☐
Cancel dependent(s) listed below from Family Coverage	☐	☐	☐	☐	☐	☐	☐

Requested Effective Date _____/_____/_____ *(Date must be included or form will be returned)*
Note: You will be billed for prorata premiums or for premiums that are not deducted.

Reason for Status Change(s)

Changes cannot be processed without the appropriate documentation as explained in the member handbook for starred (*) items. ***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.***

- ☐ Adoption of a child* *(need adoption papers)*
- ☐ Birth of a child* *(need birth certificate)*
- ☐ Death of spouse/dependent* *(need death certificate)*
- ☐ Dependent loss of coverage* *(need proof of loss of coverage)*
- ☐ Divorce/Annulment* *(need divorce decree)*
- ☐ FMLA/LOA
- ☐ Legal custody of a child* *(need legal custody papers)*
- ☐ Marriage* *(need marriage certificate & add'l proof of marriage)*
- ☐ Marriage of dependent child
- ☐ Open Enrollment
- ☐ Termination of spouse/dependent employment*
- ☐ Commencement of spouse/dependent employment*
- ☐ Medicare/Medicaid entitlement* *(need copy of card)*

Date change occurred ***(Required)*** _____/_____/_____

Dependent Information *(only required for family coverage)*

Note: *Social Security Number is required for all dependents.* *Name must be entered as it appears on the Social Security card.* *Enrollments cannot be processed without appropriate documentation for starred (*) items.* ***Birth certificates are required*** *for all children and marriage certificates for spouses.*

Name of Dependent *(First, MI, Last)*	Social Security Number	Date of Birth	Relationship to Subscriber	Sex	
			☐ Husband ☐ Wife	☐ M ☐ F	_____/_____/_____ Marriage Date
			☐ Biological ☐ Adopted* ☐ Step* ☐ Other* ______	☐ M ☐ F	Handicapped ☐ Yes ☐ No
			☐ Biological ☐ Adopted* ☐ Step* ☐ Other* ______	☐ M ☐ F	Handicapped ☐ Yes ☐ No
			☐ Biological ☐ Adopted* ☐ Step* ☐ Other* ______	☐ M ☐ F	Handicapped ☐ Yes ☐ No
			☐ Biological ☐ Adopted* ☐ Step* ☐ Other* ______	☐ M ☐ F	Handicapped ☐ Yes ☐ No

**Additional (Non-PEEHIP) Group Health Insurance Coverage Information

This section must be completed if the member elects the PEEHIP Supplemental Plan **or** if the member or dependent(s) have other group health, dental, or vision coverage currently in effect.

Name of Insurance Company	Policy Number
Name of Policy Holder	**Relationship to Policy Holder**
Policy Effective Date _____/_____/_____	**Type of Coverage** ☐ Single ☐ Family
Name of Insurance Company	**Policy Number**
Name of Policy Holder	**Relationship to Policy Holder**
Policy Effective Date _____/_____/_____	**Type of Coverage** ☐ Single ☐ Family

Medicare Information

This section must be completed if you or your dependents are eligible for Medicare.
If a member or dependent is under age 65, the PEEHIP office must receive a photostatic copy of the Medicare card before the premiums can be reduced.

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 Medicare Part D, you are not eligible for the PEEHIP prescription drug plan coverage.*

Retiree Other Employer Information

The following fields need to be completed only by PEEHIP members who retired after September 30, 2005.

Pursuant to Act 2004-649, if you retired after September 30, 2005, and become employed by another employer and the other employer provides at least 50% of the cost of single health insurance coverage, you are required to use the other employer's health benefit plan for primary coverage. You may enroll in the PEEHIP Supplemental Plan or the PEEHIP Optional Plans.

Are you employed? ☐ Yes ☐ No | If yes, please complete the employer information below.

Employer	Date of Employment	Last Day Employed
	_____/_____/_____	_____/_____/_____

Mailing Address	City	State	ZIP Code

Are you eligible for health insurance with your employer? ☐ Yes ☐ No

If yes, will your employer pay at least 50% of the cost of single health insurance coverage? ☐ Yes ☐ No

Name of Insurance Company	Policy Effective Date	Type of Coverage
	_____/_____/_____	☐ Single ☐ Family

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.

Employee Signature _____ Date Signed _____/_____/_____

Mailing Address	City	State	ZIP Code

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