PEEHIP Enroll
(06/11)
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HEALTH INSURANCE AND OPTIONAL ENROLLMENT APPLICATION

Check One:
☐ Active Member
☐ Retired

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 enroll in new coverages.
Any other changes are to be made on the Health Insurance and Optional Status Change Form.
In lieu of completing and mailing this form, you can enroll 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 your Social Security card.

Social Security Number ______-______-______	First Name	Middle Name/Initial	Last Name

Mailing Address	City	State	ZIP Code

Date of Birth ______/______/______	Home Phone ______-______-______	Work Phone ______-______-______	Sex ☐ Male ☐ Female

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

Employer/School System	Email Address	Date of Employment ______/______/______

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.

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.

Basic Hospital/Medical
(*Select only one of the three plans*)

***Note:** PEEHIP plans are administered by Blue Cross and Blue Shield of AL*

Coverage Type:
☐ PEEHIP Hospital/Medical
☐ PEEHIP Hosp/Med Supplemental**(*see Group Health on back*)
This plan is not a Medicare supplement & differs from Optional Plans.
☐ VIVA Health Plan (HMO)

☐ Single or ☐ Family

Requested Effective Date ______/______/______ ***(required)***

Primary Care Physician *(HMO only)*

Optional Coverage(s)
(*administered by Southland National*)

***Note:** Optional plans must be all Single or all Family*

Coverage Type(s):
☐ Cancer ☐ Dental ☐ Indemnity ☐ Vision

☐ Single or ☐ Family

Requested Effective Date ______/______/______ ***(required)***

Optional coverage(s) must be retained for one year until the following October 1. PEEHIP will not automatically cancel any coverage(s). All cancellations must be indicated on the Health Insurance Status Change form.

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
			☐ 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 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 _____/_____/_____

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