PEEHIP REV
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RETIREE EMPLOYMENT VERIFICATION

Public Education Employees' Health Insurance Plan
P. O. Box 302150 ♦ Montgomery, AL 36130-2150
334-517-7000 or 877-517-0020
www.rsa.state.al.us

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

Home Phone	

EMPLOYMENT INFORMATION

Are you employed? ☐ Yes ☐ No If no, go to the Medicare Information section below. Sign and date the form and return it to the address above.

Current Employer	Employer's Phone	Employment Hire Date
	_____-_____-_____	_____/_____/_____

Employer's Address	City	State	ZIP Code

Does your employer offer group health insurance? ☐ Yes ☐ No

If no, go to the Medicare Information section below. Sign and date the form and return it to the address above.

Does your employer contribute at least 50% or more of the cost of single health insurance coverage for its employees? ☐ Yes ☐ No

If no, go to the Medicare Information section below. Sign and date the form and return it to the address above.

Are you eligible for your employer's group health insurance coverage? ☐ Yes ☐ No

If yes, date you are eligible for your employer's coverage: ____________________

If no, please explain why not. ____

____

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MEDICARE INFORMATION

Are you eligible for Medicare? ☐ Yes *(complete the Medicare Information below)* ☐ No

This section must be completed if you or your dependents are eligible for Medicare. Note: You MUST have BOTH Part A and Part B to have adequate coverage under PEEHIP. If you fail to timely enroll in Part B, you are financially liable for medical costs incurred as PEEHIP will only pay 20% of the Medicare allowable fees.

Name	Medicare Card Number	Eligible for Medicare Part:	Effective Date
		☐ A ☐ B ☐ D*	_____/_____/_____
Name	Medicare Card Number	Eligible for Medicare Part:	Effective Date
		☐ A ☐ B ☐ D*	_____/_____/_____

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

PEEHIP SUBSCRIBER CERTIFICATION

I hereby affirm that I have completely read and fully understand the terms and conditions of this form. I attest that all representations made by me on this form are true and complete. I understand that any misrepresentations may result in the forfeiture of insurance coverage and that I will be personally liable for all claims related to such misrepresentation.

Retiree Signature ________________________________ Date Signed _____/_____/_____

Sign, date and return the form to the address above.

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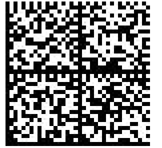

Under Alabama law, Code of Alabama 1975, Section 16-25A-5.2(1), if you retired after September 30, 2005, and are employed by another employer that provides at least 50% of the cost of single health insurance coverage, you must use your new employer's health benefit plan for primary coverage. If you are required to take your new employer's health insurance, the Public Education Employees' Health Insurance Plan (PEEHIP) offers supplemental and optional coverages at little to no cost. Please visit the PEEHIP website, www.rsa-al.gov, or contact PEEHIP for more information on the supplemental and optional coverages.

You can re-enroll in PEEHIP without a break in coverage if your new employer stops paying at least 50% of the cost of single coverage or if you should lose your other employer's health insurance coverage.

All employees who retired after September 30, 2005, are required to complete the form on the reverse side of this letter and return it to the PEEHIP office in the enclosed envelope. You mustÁæ|•[Á&[}œ&oÁÚÒÒPQÚÁ about subsequent employment changes if other group health insurance coverage is made available to you.

Any employee or retiree who knowingly and willfully submits materially false information to the PEEHIP office shall repay all claims and other expenses incurred by the plan related to false or misleading information submitted by the employee or retiree, in addition to a charge based on the applicable interest rate (Code of Alabama 1975, Section 16-25A-20).

PEEHIP must be notified if you or any of your covered dependents become eligible for Medicare prior to age 65. Once you and/or any of your covered dependents are eligible for Medicare, Medicare becomes the primary coverage and PEEHIP provides secondary coverage. Medicare eligible members/dependents must have both Medicare Parts A and B to have adequate health insurance coverage. Please complete the Medicare information on the reverse side of this letter if applicable.

Thank you for providing this information to our office. If we can be of further service, please do not hesitate to contact us.