FORMER SPOUSE NOTICE OF ELECTION (NOE)

SOUTH CAROLINA PUBLIC EMPLOYEE BENEFIT AUTHORITY

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You must also complete a *Certification Regarding Tobacco Use* form within 31 days of enrolling in health coverage and whenever the status of tobacco use changes for you or a dependent covered under your health insurance.

See Instructions - if completing by hand use black ink

ELIGIBILITY

In its *Plan of Benefits* effective January 1, 2018, the State Health Plan shall cover a subscriber's former spouse, who is eligible to be covered pursuant to a court order, on the former spouse's own individual policy and at the full amount of the premium for the coverage elected, with such rates, billing, and other administrative policies to be determined by PEBA. The former spouses may only elect health, dental, and vision coverage as required by the court order. The former spouse's individual coverage may continue under the State Health Plan as long as authorized under the court order and the subscriber remains a participant in the State Health Plan.

Employee/Retiree Social Security number (SSN)

Date of divorce (MM/DD/YYYY)

ACTION

Select ONE:

- New subscriber
- Change in coverage election
- Terminate coverage (If you terminate coverage, you have waived your right to coverage as a former spouse.)

PEBA USE ONLY

Employer ID

Effective Date

Group ID#

ENROLLEE INFO

1. Soc Sec # (SSN)	BIN #	2. Last Name	3. Suffix	4. First Name	5. M.I.	6. Date of Birth (MM/DD/YYYY)

7. Sex	8. Home Phone #	9. Email Address
M F		

10. Mailing Address	11. Apt.	12. City	13. State	14. Zip Code	15. County Code

COVERAGE

16. HEALTH PLAN ***(Refuse or select one plan and one level of coverage)***

PLAN	COVERAGE LEVEL
Refuse	Subscriber only
Standard	
Savings	
Medicare Supplemental	

17. DENTAL *(Refuse or select one plan and one level of coverage)*

PLAN	COVERAGE LEVEL
Refuse	Subscriber only
Dental Plus	
Basic Dental	

18. VISION CARE *(select one)*

Refuse Subscriber only

MEDICARE

19. Complete if you are eligible for Medicare Part A and/or Part B

Name	Medicare #	Eligible due to	Effective Date Part A (MM/DD/YYYY)	Effective Date Part B (MM/DD/YYYY)
		Age Disability Renal Disease		

CERTIFICATION & AUTHORIZATION

CERTIFICATION: I have read this NOE and made authorizations herein and selected the coverage noted. I understand and agree that all selected plans will not become effective unless and until this NOE is submitted and the first payment is made. I understand my continuation of coverage rights and responsibilities, as explained in the election notice and attachments provided to me. I also understand that the state reserves the right to alter benefits or premiums at any time to preserve the financial stability of the Plan. I further acknowledge that the eligibility status of any covered individual is subject to audit at any time.

AUTHORIZATION: I authorize any healthcare provider, prescription drug dispenser and claims administrator to release any information necessary to evaluate, administer and process claims for any benefits.

Enrollee Signature ______________________ Date ______________

INSTRUCTIONS FOR COMPLETING THE FORMER SPOUSE NOTICE OF ELECTION (NOE)

You must also complete a *Certification Regarding Tobacco Use* form within 31 days of enrolling in health coverage and whenever the status of tobacco use changes for you or a dependent covered under your health insurance.

ELIGIBILITY: Provide the employee/retiree's SSN and the date of divorce in the spaces provided.

ACTION: If you are enrolling for the first time, select New Subscriber. If you are making a change to your coverage, select Change of Coverage Election.

ENROLLEE INFORMATION: Blocks 1-15 must be completed for all transactions, including termination of coverage. **In block 15**, enter the county code of your mailing address. Explanation of Benefits, billing statements, and other correspondence will be mailed to the address provided on the NOE.

COUNTY CODES:

01 Abbeville	07 Beaufort	13 Chesterfield	19 Edgefield	25 Hampton	31 Lee	37 Oconee	43 Sumter
02 Aiken	08 Berkeley	14 Clarendon	20 Fairfield	26 Horry	32 Lexington	38 Orangeburg	44 Union
03 Allendale	09 Calhoun	15 Colleton	21 Florence	27 Jasper	33 McCormick	39 Pickens	45 Williamsburg
04 Anderson	10 Charleston	16 Darlington	22 Georgetown	28 Kershaw	34 Marion	40 Richland	46 York
05 Bamberg	11 Cherokee	17 Dillon	23 Greenville	29 Lancaster	35 Marlboro	41 Saluda	99 Out of S.C
06 Barnwell	12 Chester	18 Dorchester	24 Greenwood	30 Laurens	36 Newberry	42 Spartanburg	

COVERAGE. ALTERATIONS IN THIS SECTION ARE NOT ALLOWED:
Please make one mark for each block. Multiple marks in a block will be rejected.

Block 16. HEALTH: Select one health plan and one level of coverage or select Refuse. Changes from one health plan to another are allowed only during designated enrollment periods (exception: changing plans due to eligibility for Medicare). The Savings Plan is available only to people not enrolled in Medicare. If you refuse health coverage or fail to enroll yourself within 30 days of eligibility, you have waived your right to coverage as a Former Spouse.

Block 17. DENTAL: If you refuse dental when first eligible, you can apply for coverage for yourself and your dependent(s) only during an open enrollment period during an odd-numbered year or within 31 days of a special eligibility situation.

Block 18. VISION CARE: Select a level of vision care coverage to enroll or Refuse. If you refuse coverage or fail to enroll yourself within 30 days of eligibility, you have waived your right to coverage as a Former Spouse.

Block 19: MEDICARE List your information if you are eligible for Medicare Part A and/or Part B. Include a copy of your card.

CERTIFICATION AND AUTHORIZATION: Read this block carefully, sign and date form. Send the original form and signed, file-stamped copy of a court order to:

PEBA Insurance Benefits
P.O. Box 11661
Columbia, SC 29211

Keep a copy for your records.