SURVIVOR NOTICE OF ELECTION (NOE)

SOUTH CAROLINA PUBLIC EMPLOYEE BENEFIT AUTHORITY

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See Instructions - if completing by hand use black ink

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

Select One or Both
- Surviving Spouse
- Surviving Dependent Child(ren)

Are you an active employee of a state agency, public school district or other PEBA Insurance Benefits-covered Employer? Yes No

Information concerning deceased
Name ______________________
SSN ______________ Date of Death ______________
Killed in line of duty? Yes No

Verification of eligibility *(required of retirees from employers other than state agencies and school districts)*

Benefits Administrator Signature ______________________ Employer ID: ______________

ACTION

Select One
- New Subscriber
- Termination
- Change *(Specify)* ______________________

Date of Change Event ______________ SSN Change - Incorrect # ______________ *(Attach copy of Social Security card)*

Name Change - Prior Name ______________________

PEBA Use Only
Employer ID: ______________
Effective Date: ______________
Group ID: ______________

ENROLLEE INFO

1. Social Security number or BIN	2. Last Name	3. Suffix	4. First Name	5. M.I.	6. Date of Birth (MM/DD/YYYY)

7. Sex	8. Marital Status	9. Home Phone #	10. Email Address
M F	Single Divorced Widowed Married Separated		

11. Mailing Address	12. Apt.	13. City	14. State	15. Zip Code	16. County Code

COVERAGE

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

PLAN
- Refuse
- Medicare Supplement
- Standard
- Savings (not Medicare-eligible)
- TRICARE Supplement (not Medicare-eligible)

COVERAGE LEVEL
- Surviving Spouse
- Surviving Spouse/Child(ren)
- Child(ren) only

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

PLAN
- Refuse
- Dental Plus
- Basic Dental

COVERAGE LEVEL
- Surviving Spouse
- Surviving Spouse/Child(ren)
- Child(ren) only

19. VISION CARE *(select one)*
- Refuse
- Surviving Spouse
- Surviving Spouse/Child(ren)
- Child(ren) only

MEDICARE

20. List yourself and any other persons to be covered who 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		
		Age Disability Renal Disease		

DEPENDENTS

21. Always list spouse. List eligible children to be covered. If they are not listed, they will not be covered. For a child age 19-24 to be eligible for Dependent Life-Child coverage, your child must be eligible according to the requirements on the instructions page for this NOE.

Add (A) or Delete (D)	Dependent SSN	Last Name	First Name	Sex	Relationship	Date of Birth (MM/DD/YYYY)	Indicate Special Status
	Spouse						Does PEBA Insurance Benefits already cover your spouse? Yes No
	Child						Incapacitated
	Child						Incapacitated
	Child						Incapacitated
	Child						Incapacitated

CERTIFICATION & AUTHORIZATION

22. CERTIFICATION: I have read this NOE and made authorizations herein and selected the coverage noted. I have provided Social Security numbers and documentation establishing my dependent(s)' eligibility for the plan(s) selected. 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 COBRA continuation 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.

DISCLAIMER: THE LANGUAGE USED IN THIS DOCUMENT DOES NOT CREATE AN EMPLOYMENT CONTRACT BETWEEN THE EMPLOYEE AND THE AGENCY. THIS DOCUMENT DOES NOT CREATE ANY CONTRACTUAL RIGHTS OR ENTITLEMENTS. THE AGENCY RESERVES THE RIGHT TO REVISE THE CONTENT OF THIS DOCUMENT IN WHOLE OR IN PART. NO PROMISES OR ASSURANCES, WHETHER WRITTEN OR ORAL, WHICH ARE CONTRARY TO OR INCONSISTENT WITH THE TERMS OF THIS PARAGRAPH CREATE ANY CONTRACT OF EMPLOYMENT.

Enrollee/Guardian Signature ______________________ Date ______________

INSTRUCTIONS FOR COMPLETING THE SURVIVOR 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: The spouse and dependent children of a deceased employee/retiree, who are insured/covered when the employee/retiree dies, can continue their same coverage. A surviving spouse and dependents who are *not* covered at the time of death may not enroll. Indicate whether you are an active employee of a state agency, public school district or other participating employer. Complete the information concerning the deceased employee or retiree.

ACTION: If you are enrolling as a survivor for the first time, check New Subscriber. If you are already enrolled and are making a change, select Change and indicate the type of change and date of the change event. If you wish to end your coverage, select Termination.

ENROLLEE INFORMATION: Blocks 1-16 must be completed for all transactions including termination of coverage. Enrollee information should be for the surviving spouse, unless coverage is only for dependent child(ren). If coverage is only for dependent child(ren), enrollee information should be for the youngest child or, if applicable, for a child covered under Medicare; additional children should be included as dependents in block 22. In block 16, indicate the county code of your mailing address.

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:
Block 17. HEALTH: Select one health plan and one level of coverage or select Refuse. If you refuse health, dental and vision coverage or fail to enroll yourself and all eligible dependents within 30 days of eligibility, you lose your eligibility for coverage as a survivor, and you cannot enroll later. 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 non-Medicare enrollees and dependents.

Block 18. 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. For dependents to be covered, they must be listed in **Block 21**, and the appropriate level of coverage must be selected.

Block 19. VISION CARE: Select a level of vision care coverage to enroll or Refuse. If you refuse coverage or fail to enroll yourself and all eligible dependents within 30 days of eligibility, you can enroll yourself and/or your dependents during the next enrollment period (October) or within 30 days of a special eligibility situation.

Block 20: MEDICARE List yourself and any other persons to be covered who are eligible for Part A and/or Part B of Medicare. Please contact PEBA Insurance Benefits if you or your dependents are eligible for Medicare before you elect COBRA coverage.

Block 21. DEPENDENTS: Legal documentation is required for all dependents. If you select a level of coverage that includes a spouse and/or dependent child(ren), they must be listed to be covered. A spouse can only be covered as a dependent if he is not an employee or retiree of an employer that participates in the state of South Carolina Insurance Benefits Program. If your spouse is an employee or retiree of an employer covered by PEBA insurance, check Yes. A child younger than 26 is eligible for health, dental and vision coverage. Misstatements on the NOE may result in termination of the dependent's coverage and recoupment of benefits paid on behalf of the ineligible dependent.

CERTIFICATION AND AUTHORIZATION: Read this block carefully, sign and date form. Send the original form and any required documentation to PEBA Insurance Benefits, P.O. Box 11661, Columbia, SC 29211. Keep a copy for your records.