You must also complete a Tobacco Certification form within 30 days of enrolling in health coverage and whenever the status of tobacco use changes for you or a dependent covered under your health insurance.

ACTIVE EMPLOYEE NOTICE OF ELECTION (NOE)
SOUTH CAROLINA PUBLIC EMPLOYEE BENEFIT AUTHORITY
INSURANCE BENEFITS

Clear Form

A
See Instructions - If Completing By Hand Use Black Ink

ACTION

Select One:	Type of Change	BA Use Only	MoneyPlus Pretax Premiums
☐ New Hire ☐ Transfer ☐ Change	☐ Enrollment Other *(specify)* _____ Date of Change Event: _____	Effective Date: _____ ☐ Permanent P/T EE *(20 hrs.)* Group ID #: _____ Group Name: _____	☐ Refuse ☐ Yes

Eligible due to the Affordable Care Act: ☐ Full-time nonpermanent ☐ Variable-Hour

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. Marital Status	9. Home Phone #	10. Work Phone #	11. E-mail Address
☐ M ☐ F	☐ Single ☐ Widowed ☐ Married ☐ Divorced ☐ Separated			

12. Mailing Address	13. Apt.	14. City	15. State	16. Zip Code	17. County Code	18. Annual Salary	19. Date of Hire MM/DD/YYYY

MEDICARE

20. List yourself and any other persons to be covered who are eligible for Part A and/or Part B of Medicare.

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		

COVERAGE

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

PLAN ☐ Refuse ☐ TRICARE Supplement ☐ Standard ☐ Savings

Basic Life and Basic Long Term Disability included automatically with health plan coverage

COVERAGE LEVEL
☐ Employee ☐ Employee/Child(ren)
☐ Employee/Spouse ☐ Family

22. STATE DENTAL PLAN *(Select One)*
☐ Refuse ☐ Employee/Spouse
☐ Employee ☐ Employee/Child(ren)
☐ Family

23. DENTAL PLUS *(Select One)*
☐ Refuse
☐ Yes

24. DEPENDENT LIFE - Child(ren) *(Select One)*
☐ Refuse
☐ $15,000

25. DEPENDENT LIFE - Spouse *(Select One)*
☐ Refuse ☐ Coverage Level
$_____
(Must be in increments of $10,000)

26. OPTIONAL LIFE *(Select One)*
☐ Refuse ☐ Coverage Level
$_____
(Must be in increments of $10,000)

27. SUPPLEMENTAL LTD *(Select One)*
☐ Refuse
☐ Plan One - *90-day benefit waiting period*
☐ Plan Two - *180-day benefit waiting period*

28. VISION CARE *(Select One)*
☐ Refuse ☐ Employee/Spouse
☐ Employee ☐ Employee/Child(ren)
☐ Family

BENEFICIARIES

In blocks 29 and 30, if there are additional beneficiaries or dependents, list on separate sheet, signed and dated by employee.

29. Basic Life/Optional Life *(Select one or both)*	SSN#	Last Name	First Name	Relationship	Date of Birth MM/DD/YYYY	Primary or Contingent?
☐ Basic Life ☐ Optional Life						☐ Primary ☐ Contingent
☐ Basic Life ☐ Optional Life						☐ Primary ☐ Contingent
☐ Basic Life ☐ Optional Life						☐ Primary ☐ Contingent

If beneficiary is an estate or trust, complete the following:

Estate/Trust_____Address_____If Trust, Date Signed_____

DEPENDENTS

30. 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 reverse of this NOE.

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

CERTIFICATION & AUTHORIZATION

31. 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 certify that any child enrolled in Dependent Life/Child insurance is eligible according to the requirements on the reverse of this NOE. I also understand that proof of eligibility (at the time of enrollment and at the time of the claim) will be required before any Dependent Life/Child insurance claim is paid. I understand that unless otherwise provided in the Plan, I may cancel coverage for me or my dependent(s) only during an open enrollment period. Should I refuse any coverage or fail to enroll all eligible dependents when first eligible, I and/or all eligible dependents may only enroll during an open enrollment period unless otherwise provided by the Plan. I understand and agree that all selected plans will not be effective unless and until the NOE is approved. I 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 hereby authorize my employer to deduct from my salary premiums necessary to pay for all plans selected and verify my salary for enrollment. 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.

Employee Signature _____ Date _____

32. I hereby attest the employee meets eligibility requirements, proper premiums are being collected, this form is complete and accurate and all required documentation is attached to process NOE form.

Benefits Administrator Signature _____ Phone _____ Date _____

INSTRUCTIONS FOR COMPLETING THE ACTIVE NOTICE OF ELECTION (NOE)

IF COMPLETING BY HAND, USE BLACK INK

You must also complete a Tobacco Certification form within 30 days of enrolling in health coverage and whenever the status of tobacco use changes for you or a dependent covered under your health insurance.

ACTION: Indicate type of action. MoneyPlus: Premiums for health, dental, vision and Optional Life up to $50,000 are deducted on a pretax basis unless refused. There is an administrative fee for the pretax deductions. Pretax MoneyPlus changes must be made during enrollment or within 30 days of a qualifying change in status event.

Blocks 1-19. ENROLLEE INFORMATION: Must be completed for all transactions, including a refusal of coverage.

Block 20. MEDICARE: List yourself and any other persons to be covered who are eligible for Part A and/or Part B of Medicare.

COVERAGE: Alterations (such as mark-throughs or white out) in this section are not allowed. To enroll, select the coverage and select the coverage level, if applicable. To refuse or cancel coverage, select "Refuse."

Block 21. HEALTH: Before making a health plan selection, refer to the plan descriptions provided by your employer.

If you refuse health coverage or fail to enroll all eligible dependents when first eligible, you can enroll yourself and/or your dependent(s) only during an open enrollment period or within 30 days of a special eligibility situation. If health coverage is refused, benefits for Basic Life and Basic Long Term Disability are forfeited.

To select a health plan, check only one block under "Health Plan" and check only one block under "Coverage Level." For dependent(s) to be covered, they must be listed in Block 30, and the appropriate level of coverage must be selected.

Block 22. 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 30 days of a special eligibility situation. For dependents to be covered, they must be listed in Block 30, and the appropriate level of coverage must be selected.

Block 23. DENTAL PLUS: You must enroll in the State Dental Plan to enroll in Dental Plus. You must also cover the same family members under both plans.

Block 24. DEPENDENT LIFE—CHILD(REN): For child(ren) to be covered for Dependent Life Insurance, they must be listed in **Block 30**. To be eligible, they must be unmarried; must be supported by you; must not be employed on a full-time basis; and must not be in the military. In addition, for a child age 19-24 to be eligible the child must be certified by the PEBA Insurance Benefits as incapacitated at the time of enrollment or must be a full-time student at an accredited school, college or university. Children older than 24 must be certified by PEBA Insurance Benefits as incapacitated to be enrolled in Dependent Life-Child. Proof of eligibility, at the time of enrollment and at the time of the claim, will be required before any benefit will be paid.

Block 25. DEPENDENT LIFE—SPOUSE: Before making a selection, refer to the detailed instructions provided by your employer.
To select coverage, check "Coverage Level" and enter the amount of coverage for your spouse, not to exceed 50 percent of your current level of Optional Life, or $100,000. Approved medical evidence of good health is required if coverage exceeds $20,000. For your spouse to be covered, he must be listed in **Block 30.**

Block 26. OPTIONAL LIFE: Before making a selection, refer to the detailed instructions provided by your employer.

To select coverage, check "Coverage Level" and enter the amount of coverage. Coverage level may be based on your current salary (newly enrolled), a guaranteed issue and/or approved medical evidence of good health. If you do not enroll within 30 days of your date of hire, medical evidence of good health must be provided and approved to enroll or increase coverage level. However, if enrolled in the MoneyPlus Pretax Premium Feature, you must wait until the next enrollment period or within 30 days of a special eligibility situation.

Block 27. SUPPLEMENTAL LONG TERM DISABILITY: Before making a selection, refer to the detailed instructions provided by your employer.

Check only one block. If changing from "Plan Two" to "Plan One," medical evidence of good health must be provided.

Block 28. VISION CARE: Before making a selection, refer to the plan description provided by your employer.

Block 29. BENEFICIARIES: List a beneficiary for Basic Life if enrolled in health coverage and Optional Life if selected. Multiple beneficiaries may be listed. Beneficiaries must be listed individually by a name or organization. Unless otherwise provided herein, if two or more beneficiaries are named, the proceeds shall be paid in equal shares to the named survivors. Contingent beneficiaries have no rights unless all primary beneficiaries have died.

Block 30. 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 a PEBA Insurance Benefits-covered employer, 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: Form must be signed and dated by employee within 30 days of hire or the qualifying event.

The benefits administrator must sign and date form and attach copies of all supporting documentation before submitting it to the **PEBA Insurance Benefits at P.O. Box 11661 Columbia, SC 29211-1661.**