You must also complete a Tobacco Certification 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.

RETIREE NOTICE OF ELECTION (NOE)

SOUTH CAROLINA PUBLIC EMPLOYEE BENEFIT AUTHORITY
INSURANCE BENEFITS

Clear Form

R See Instructions - If Completing By Hand Use Black Ink

ELIGIBILITY

Select
- ☐ Regular Retiree
- ☐ Disability Retiree
- ☐ Police Retiree

Indicate Record of Service *(Attach Employment Record)*

_____Yrs. _____Mos. _____Days

Select ONE *(If Applicable)*
- ☐ 5-10 Year Retiree
- ☐ Age 55/25 Years Retiree Ending Date _____
- ☐ TERI Retiree Ending Date _____

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 - Date of Retirement_____ ☐ Termination
- ☐ Previously enrolled as a Retiree - returning to Retiree status
- ☐ Change *(Specify)*_____
- SSN Change - Incorrect #_____ Date of Change Event_____
  (Attach Copy of Social Security Card)

PEBA INSURANCE BENEFITS 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. Marital Status		9. Home Phone #	10. E-mail Address
☐ M ☐ F	☐ Single ☐ Married	☐ Widowed ☐ Divorced ☐ Separated	( )	

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

COVERAGE

It is your responsibility to select the appropriate insurance coverage. See the instructions before making your selection. Alterations in this section are not allowed.

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

PLAN	COVERAGE LEVEL
☐ Refuse ☐ Medicare Supplement	☐ Retiree
☐ Standard	☐ Retiree/Spouse
☐ Savings (not Medicare-eligible)	☐ Retiree/Child(ren)
☐ TRICARE Supp (not Medicare-eligible)	☐ Family

18. STATE DENTAL PLAN
- ☐ Refuse
- ☐ Retiree
- ☐ Retiree/Spouse
- ☐ Retiree/Child(ren)
- ☐ Family

19. DENTAL PLUS *(Select One)*
- ☐ Refuse ☐ Yes

You must be enrolled in the State Dental Plan to select Dental Plus.

20. VISION CARE *(Select One)*
- ☐ Refuse
- ☐ Retiree
- ☐ Retiree/Spouse
- ☐ Retiree/Child(ren)
- ☐ Family

MEDICARE

21. List yourself and any other persons to be covered who are eligible for Part A and/or Part B of Medicare. Please include copy of Medicare card.

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		
		☐ Age ☐ Disability ☐ Renal Disease		

DEPENDENTS

22. Always list spouse. List all children to be covered. If they are not listed, they will not be covered. For children older than 25 to be eligible for coverage, submit an Incapacitated Child Certification Form.

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						☐ Incapacitated
	Child						☐ Incapacitated
	Child						☐ Incapacitated

CERTIFICATION & AUTHORIZATION

23. CERTIFICATION: I have read this NOE and made authorizations herein and selected the coverages noted. I have provided Social Security numbers and documentation establishing my dependent(s)' eligibility for the plan(s) selected. 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 understand that it is my sole responsibility to pay all required premiums for all plans selected.

Failure to pay the required premiums by the due dates will result in cancellation of coverage. 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 Signature_____ Date _____

INSTRUCTIONS FOR COMPLETING THE RETIREE NOTICE OF ELECTION (NOE)

You must complete a Tobacco Certification 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: For new retirees only. Select a retiree type to indicate your eligibility as a retiree. Enter the length of service, and complete and attach the Employment Verification Record form. If your most recent hire date is on or after July 1, 1984, and you have fewer than 10 years service credit, check the "5-10 year retiree" block. Check the "age 55/25 years retiree" block if you are retiring under the "age 55 with 25 years service credit" provision, and enter the date you will reach age 60 or 28 years, whichever occurs first. Check the TERI retiree block if you are retiring under the South Carolina Retirement System Teacher and Employee Retention Incentive program (TERI) provision, and indicate the ending date. Employer verification of eligibility is required only for retirees of participating cities, counties, disabilities and special needs boards, water and sewer districts, alcohol and drug abuse agencies, special hospital districts, special purpose districts, recreation districts and municipalities.

ACTION: If you are enrolling as a retiree for the first time, check "New Subscriber" and enter your date of retirement. If you are already enrolled as a retiree and are making a change, check "Change" and indicate the type of change and date of the event causing the change. If you were previously enrolled as a retiree and are now returning to retiree coverage, check "Previously enrolled as a Retiree - returning to Retiree status." If you wish to end your retiree coverage, check "Termination."

ENROLLEE INFO: Blocks 1-16 must be completed for all transactions including terminations. **In block 16**, enter the county code (listed below) of your mailing address.

COUNTY CODES:

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

COVERAGE. ALTERATIONS IN THIS SECTION ARE NOT ALLOWED:

Block 17. HEALTH: Select one health plan and one level of coverage or check "Refuse." If you refuse health coverage or fail to enroll yourself and all eligible dependents within 31 days of eligibility, you can enroll yourself and/or your dependent(s) only during an open enrollment period or within 31 days of a special eligibility situation. Changes from one health plan to another are allowed only during designated enrollment periods (exceptions: changing plans due to Medicare eligibility). The Savings Plan is available only to non-Medicare-eligible enrollees and dependents.

Block 18. DENTAL: Select level of dental coverage or "Refuse." If you refuse dental coverage or fail to enroll yourself and all eligible dependents within 31 days of eligibility, you can enroll yourself and/or your dependents only during an open enrollment period in an odd-numbered year or within 31 days of a special eligibility situation.

Block 19. DENTAL PLUS: Select "Yes" to enroll or "Refuse". 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 20. 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 31 days of eligibility, you can enroll yourself and/or your dependents during the next enrollment period (October) or within 31 days of a special eligibility situation.

MEDICARE: In block 21, list yourself and any other persons to be covered who are eligible for Part A and/or Part B of Medicare.

Block 22. DEPENDENTS: Legal documentation is required for all dependents. List your spouse and whether he is an employee or retiree of a PEBA Insurance Benefits-covered employer. A spouse can only be covered as a dependent if his is not an employee or retiree of an employer that participates in the State of South Carolina Insurance Benefits Program. List all dependents to be covered. If they are not listed, they will not be covered.

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 block 23 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.