

You must also complete a Tobacco Certification form whenever the status of tobacco use changes for you or a dependent covered under your health insurance.

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



See Instructions - If Completing
By Hand Use Black Ink

ELIGIBILITY	Select ONE or BOTH: <input type="checkbox"/> Surviving Spouse <input type="checkbox"/> Surviving Dependent Child(ren)	Are you an active employee of a state agency, public school district or other PEBA Insurance Benefits-covered employer? <input type="checkbox"/> YES <input type="checkbox"/> NO	Information Concerning Deceased Name _____ SSN _____ Date of Death _____	Killed in line of duty? <input type="checkbox"/> YES <input type="checkbox"/> NO
	Verification of Eligibility (required of subscribers from employers other than state agencies and school districts) Benefits Administrator Signature _____ Employer ID _____			

ACTION	Select ONE: <input type="checkbox"/> New Subscriber <input type="checkbox"/> Termination <input type="checkbox"/> Change (Specify) _____ Date of Change Event _____ SSN Change - Incorrect # _____ Name Change - Prior Name _____ (Attach Copy of Social Security Card)	PEBA INSURANCE BENEFITS USE ONLY Employer ID _____ Effective Date _____ Group ID# _____
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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 <input type="checkbox"/> M <input type="checkbox"/> F	8. Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	9. Home Phone # () _____	10. E-mail Address _____			
	11. Mailing Address _____		12. Apt. _____	13. City _____	14. State _____	15. Zip Code _____	16. County Code _____	

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

COVERAGE	17. HEALTH PLAN (Refuse or select one plan and one level of coverage) PLAN <input type="checkbox"/> Refuse <input type="checkbox"/> Medicare Supplement <input type="checkbox"/> Standard <input type="checkbox"/> Savings (not Medicare-eligible) <input type="checkbox"/> TRICARE Supp (not Medicare-eligible)	18. STATE DENTAL PLAN <input type="checkbox"/> Refuse <input type="checkbox"/> Surviving Spouse <input type="checkbox"/> Surviving Spouse/Child(ren) <input type="checkbox"/> Child(ren) Only	19. DENTAL PLUS (Select One) <input type="checkbox"/> Refuse <input type="checkbox"/> Yes You must be enrolled in the State Dental Plan to select Dental Plus.	20. VISION CARE (Select One) <input type="checkbox"/> Refuse <input type="checkbox"/> Surviving Spouse <input type="checkbox"/> Surviving Spouse/Child(ren) <input type="checkbox"/> Child(ren) Only
	COVERAGE LEVEL <input type="checkbox"/> Surviving Spouse <input type="checkbox"/> Surviving Spouse/Child(ren) <input type="checkbox"/> Child(ren) Only			

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

MEDICARE	Name	Medicare #	Eligible Due To	Effective Date	
				Part A MM/DD/YYYY	Part B MM/DD/YYYY
			<input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> Renal Disease		
			<input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> Renal Disease		
			<input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> Renal Disease		
			<input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> Renal Disease		

22. 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.

DEPENDENTS	Add (A) or Delete (D)	Dependent SSN#	Last Name	First Name	Sex M/F	Relationship	Date of Birth MM/DD/YYYY	Indicate Special Status
			Child					
		Child						<input type="checkbox"/> Incapacitated
		Child						<input type="checkbox"/> Incapacitated
		Child						<input type="checkbox"/> Incapacitated

CERTIFICATION & AUTHORIZATION	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. 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 become effective unless and until this NOE is approved. 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 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 PEBA Insurance Benefits to deduct my insurance premiums from my retirement income if sufficient. 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. <u>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.</u>
	Enrollee/Guardian Signature _____ Date _____	

SURVIVOR NOTICE OF ELECTION FORM INSTRUCTIONS

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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	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 select "Refuse." If you refuse health, dental and vision coverage or fail to enroll yourself and all eligible dependents within 31 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: Select the level of dental coverage or "Refuse." If you refuse health, dental and vision coverage or fail to enroll yourself and all eligible dependents within 31 days of eligibility, you lose your eligibility for coverage as a survivor, and you cannot enroll later.

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 ALL coverage or fail to enroll yourself and all eligible dependents within 31 days of eligibility, you lose your eligibility for coverage as a survivor, and you cannot enroll later.

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 all children 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 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.