ACTIVE NOTICE OF ELECTION (NOE)

SOUTH CAROLINA PUBLIC EMPLOYEE BENEFIT AUTHORITY

A

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.

Clear Form

ACTION

Select One	Type of Change	BA Use Only
☐ New Hire/Election	☐ Enrollment	Effective Date: _____ ☐ Permanent P/T EE *(20 hrs.)*
☐ Transfer	Other (*specify*) _____	Group ID #: _____ Pay periods per year: _____
☐ Change	Date of Change Event _____	Group Name: _____

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

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. Work Phone #	11. Email Address
☐ M ☐ F	☐ Single ☐ Divorced ☐ Widowed ☐ Married ☐ Separated			

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

COVERAGE

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

PLAN	COVERAGE LEVEL
☐ Refuse	☐ Employee
☐ Standard	☐ Employee/Spouse
☐ Savings	☐ Employee/Child(ren)
☐ TRICARE Supplement	☐ Family

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

PLAN	COVERAGE LEVEL
☐ Refuse	☐ Employee
☐ Dental Plus	☐ Employee/Spouse
☐ Basic Dental	☐ Employee/Child(ren)
	☐ Family

22. DEPENDENT LIFE Child(ren) *(select one)*
☐ Refuse
☐ $15,000

23. DEPENDENT LIFE Spouse *(select one)*
☐ Refuse
☐ Total Coverage Amount
$ _____

24. OPTIONAL LIFE *(select one)*
☐ Refuse
☐ Total Coverage Amount
$ _____

25. SUPPLEMENTAL LTD *(select one)*
☐ Refuse
☐ Plan One - *90-day waiting period*
☐ Plan Two - *180-day waiting period*

26. VISION CARE *(select one)*
☐ Refuse
☐ Employee
☐ Employee/Spouse
☐ Employee/Child(ren)
☐ Family

MONEYPLUS ELECTIONS

27. MONEYPLUS ELECTIONS **MoneyPlus Pretax Premiums** ☐ Refuse ☐ Yes

If you enroll in a health savings account (Section C), you cannot enroll in a medical spending account (Section A), but may enroll in a limited-use medical spending account (Section D). There is a monthly fee of $2.32 for medical spending, dependent care, and limited-use medical spending accounts. There is a monthly fee of $1.00 for health savings accounts.

A. MEDICAL SPENDING ACCOUNT
☐ New Enrollment ☐ Re-enrollment ☐ Refuse

Receive reimbursement for eligible medical expenses incurred by you, your family members, or both. The maximum allowable contribution is $2,750 annually.

Plan year total amount: $ _____

B. DEPENDENT CARE SPENDING ACCOUNT **(for child/adult daycare)**
☐ New Enrollment ☐ Re-enrollment ☐ Refuse

Tax filing status, please check one:
☐ Married, filing separately (Maximum - $5,250) _____ Daycare costs increase/decrease
☐ Single, head of household (Maximum - $10,500) _____ Dependent child turns 13
☐ Married, filing jointly (Maximum - $10,500)

Plan year total amount: $ _____

C. HEALTH SAVINGS ACCOUNT
☐ New Account ☐ Contribution Amount Change ☐ Refuse

Select which type of State Health Plan Savings Plan coverage you have:
☐ Individual (Maximum - $3,600)
☐ Family (Maximum - $7,200)
☐ Over 55 Catch-up (additional $1,000)

Plan year total amount: $ _____

D. LIMITED-USE MEDICAL SPENDING ACCOUNT
☐ New Enrollment ☐ Re-enrollment ☐ Refuse

Receive reimbursement for eligible dental and vision expenses incurred by you, your family members, or both. The maximum allowable contribution is $2,750 annually.

Plan year total amount: $ _____

Qualified Change Events (Check and date all that apply) for A & B:

_____ Marriage	_____ Spouse/dependent passed away	_____ Spouse ends unpaid leave	_____ Other
_____ Newborn	_____ Employee begins unpaid leave	_____ Spouse begins unpaid leave	
_____ Adoption	_____ Employee ends unpaid leave	_____ Job change from part-time to full-time	
_____ Divorce	_____ Ineligible dependent child	_____ Job change from full-time to part-time	

EMPLOYEE INITIALS _____ **DATE** _____

Social Security number: _____ **BIN:** _____ **Last Name:** _____ **First Name:** _____

MEDICARE

28. 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)	Part B (MM/DD/YYYY)
		☐ Age ☐ Disability ☐ Renal Disease		
		☐ Age ☐ Disability ☐ Renal Disease		

BENEFICIARIES

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

29. Basic Life/Opt 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
☐ 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 or 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

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 *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.

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. Pretax MoneyPlus changes must be made during enrollment or within 31 days of a qualifying change in status event.

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

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 20: 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 31 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 21: 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 30**, and the appropriate level of coverage must be selected.

Block 22: 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 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 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 23: DEPENDENT LIFE - SPOUSE: Before making a selection, refer to the detailed instructions provided by your employer. To select coverage, check Total Coverage Amount and enter the total 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 24: OPTIONAL LIFE: Before making a selection, refer to the detailed instructions provided by your employer. To select coverage, check Total Coverage Amount and enter the total 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 31 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 31 days of a special eligibility situation.

Block 25: 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 26: VISION CARE: Before making a selection, refer to the plan description provided by your employer.

Block 27: MONEYPLUS ELECTIONS**:** To enroll in a **Medical Spending Account**, complete **Section A**. To enroll in a **Dependent Care Spending Account**, complete **Section B**. Complete **Section C** to enroll in or to change a **Health Savings Account**. (Additional forms will be required to establish your HSA. Refer to your *Tax-Favored Accounts Guide* for more information.) If you would also like to enroll in a **limited-used Medical Spending Account** for eligible dental and vision expenses, complete **Section D**.

Block 28. MEDICARE: List yourself and any other persons to be covered who are eligible for Part A and/or Part B of Medicare.

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 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.

Block 31. CERTIFICATION AND AUTHORIZATION: Employees must initial and date the first page in the area provided. The second page of the form must be signed and dated by employee within 31 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 **PEBA Insurance Benefits at P.O. Box 11661 Columbia, SC 29211-1661.**