

HEALTH INSURANCE AND OPTIONAL ENROLLMENT APPLICATION



Public Education Employees' Health Insurance Plan
P. O. Box 302150 ♦ Montgomery, Alabama 36130-2150
334-517-7000 or 877-517-0020
Web site: www.rsa-al.gov

This form is to be used to enroll in new coverages.

Any other changes are to be made on the Health Insurance and Optional Status Change Form.
 In lieu of completing and mailing this form, you can make your changes online using the Web site above.

Please print and complete the front and back of form.

PEEHIP Subscriber Information

Name must be entered as shown on your Social Security card.

Social Security Number ____-____-____		First Name		Middle Name/Initial	Last Name
Mailing Address			City	State	ZIP Code
Date of Birth ____/____/____	Home Phone ____-____-____	Work Phone ____-____-____	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Widowed					
Employer/School System				Date of Employment ____/____/____	

Have you or your spouse used tobacco products within the last 12 months?*
 Member: Yes No Spouse: Yes No

**This information is required for enrollment.*

PEEHIP Coverage Information

For an effective date of coverage other than October 1, there is a 270 day waiting period for pre-existing conditions unless proof of previous coverage is received and approved by the PEEHIP office.

Basic Hospital/Medical <i>(Select only one of the three plans)</i> Note: PEEHIP plans are administered by Blue Cross and Blue Shield of AL Coverage Type: <input type="checkbox"/> PEEHIP Hospital/Medical <input type="checkbox"/> PEEHIP Hosp/Med Supplemental** <i>(see Group Health on back)</i> <i>This plan is not a Medicare supplement & differs from Optional Plans.</i> <input type="checkbox"/> VIVA Health Plan (HMO) <input type="checkbox"/> Single or <input type="checkbox"/> Family		Optional Coverage(s) <i>(administered by Southland National)</i> Note: Optional plans must be all Single or all Family Coverage Type(s): <input type="checkbox"/> Cancer <input type="checkbox"/> Dental <input type="checkbox"/> Indemnity <input type="checkbox"/> Vision <input type="checkbox"/> Single or <input type="checkbox"/> Family Requested Effective Date ____/____/____ <i>(required)</i>	
Requested Effective Date ____/____/____ <i>(required)</i> Primary Care Physician <i>(HMO only)</i>		Optional coverage(s) must be retained for one year until the following October 1. The PEEHIP office will not automatically cancel any coverage(s). All cancellations must be indicated on the Health Insurance Status Change form.	

Dependent Information *(only required for family coverage)*

Note: Social Security Number is required for all dependents. *Name must be entered as it appears on the Social Security card. Enrollments cannot be processed without the appropriate documentation as explained in the Member Handbook for any starred (*) items.*

Name of Dependent <i>(First, MI, Last)</i>	Social Security Number	Date of Birth	Relationship to Subscriber	Sex	
			<input type="checkbox"/> Husband <input type="checkbox"/> Wife <input type="checkbox"/> Common-Law*	<input type="checkbox"/> M <input type="checkbox"/> F	____/____/____ Marriage Date
			<input type="checkbox"/> Biological <input type="checkbox"/> Adopted* <input type="checkbox"/> Step* <input type="checkbox"/> Other*	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Student* <i>(must complete other side)</i> <input type="checkbox"/> Handicapped*
			<input type="checkbox"/> Biological <input type="checkbox"/> Adopted* <input type="checkbox"/> Step* <input type="checkbox"/> Other*	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Student* <i>(must complete other side)</i> <input type="checkbox"/> Handicapped*
			<input type="checkbox"/> Biological <input type="checkbox"/> Adopted* <input type="checkbox"/> Step* <input type="checkbox"/> Other*	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Student* <i>(must complete other side)</i> <input type="checkbox"/> Handicapped*
			<input type="checkbox"/> Biological <input type="checkbox"/> Adopted* <input type="checkbox"/> Step* <input type="checkbox"/> Other*	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Student* <i>(must complete other side)</i> <input type="checkbox"/> Handicapped*

Student Verification (only necessary to complete for dependent children **between the ages of 19 and 25**)*If full-time student, list dependent's first name and university, college, or accredited vocational school.*

Name	School	Term Attending	Hours Enrolled
Name	School	Term Attending	Hours Enrolled

Combining of Allocations*Allocations can only be combined at certain times and only if your spouse is independently eligible for PEEHIP.*I wish to transfer receive the state insurance allocation to from my spouse.

Spouse's Social Security Number: _____ - _____ - _____ Effective Date of Combining Allocations: ____/____/____

Additional (Non-PEEHIP) Group Health Insurance Coverage Information**This section must be completed if the member elects the PEEHIP Supplemental Plan **or** if the member or dependent(s) have other group health, dental, or vision coverage currently in effect.

Name of Insurance Company	Policy Number
Name of Policy Holder	Relationship to Policy Holder
Policy Effective Date ____/____/____	Type of Coverage <input type="checkbox"/> Single <input type="checkbox"/> Family

Medicare Information

This section must be completed if you or your dependents are eligible for Medicare.

If a member or dependent is under age 65, the PEEHIP office must receive a photostatic copy of the Medicare card before the premiums can be reduced.

Name	Medicare Card Number
Check the Medicare Part(s) for which you are eligible: <input type="checkbox"/> Part A-Effective: ____/____/____ <input type="checkbox"/> Part B-Effective: ____/____/____ <input type="checkbox"/> Part D*-Effective: ____/____/____	
Name	Medicare Card Number
Check the Medicare Part(s) for which you are eligible: <input type="checkbox"/> Part A-Effective: ____/____/____ <input type="checkbox"/> Part B-Effective: ____/____/____ <input type="checkbox"/> Part D*-Effective: ____/____/____	

If you are enrolled in Medicare Part D, you are not eligible for the PEEHIP prescription drug plan coverage.*Retiree Other Employer Information**

The following fields must be completed by PEEHIP members who retire after September 30, 2005.

Pursuant to Act 2004-649, if you retire after September 30, 2005, and become employed by another employer and the other employer provides at least 50% of the cost of single health insurance coverage, you are required to use the other employer's health benefit plan for primary coverage. You may enroll in the PEEHIP Supplemental Plan or the PEEHIP Optional Plans.

Are you employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please complete the employer information below.		
Employer	Date of Employment ____/____/____	Last Day Employed ____/____/____	
Mailing Address	City	State	ZIP Code

Are you eligible for health insurance with your employer? Yes NoIf yes, will your employer pay at least 50% of the cost of single health insurance coverage? Yes No

Name of Insurance Company	Policy Effective Date ____/____/____	Type of Coverage <input type="checkbox"/> Single <input type="checkbox"/> Family
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PEEHIP Subscriber Certification

Under penalties of perjury, I declare that I have examined this form and statements, and to the best of my knowledge and belief, they are true and correct. I further understand that there is mandatory utilization review and I do hereby release any information necessary to evaluate, administer and process claims for benefits to any person, entity or representative acting on the Plan's behalf. I also agree to periodic tobacco usage testing and agree to notify the PEEHIP office if my or my spouse's tobacco status changes or if my employment status changes. I also agree to have premiums deducted from my retirement check or paycheck for any prior months that are due but were not deducted at the proper time.

Employee Signature _____ Date Signed ____/____/____

Please mail the completed form to the address located on the front of this form.