

RETIREE EMPLOYMENT VERIFICATION

Public Education Employees' Health Insurance Plan
P. O. Box 302150 ♦ Montgomery, AL 36130-2150
334-517-7000 or 877-517-0020
www.rsa.state.al.us



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
Home Phone			

EMPLOYMENT INFORMATION

Are you employed? Yes No If no, go to the Medicare Information section below. Sign and date the form and return it to the address above.

Current Employer	Employer's Phone ____-____-____	Employment Hire Date ____/____/____
Employer's Address	City	State ZIP Code

Does your employer offer group health insurance? Yes No
If no, go to the Medicare Information section below. Sign and date the form and return it to the address above.

Does your employer contribute at least 50% or more of the cost of single health insurance coverage for its employees? Yes No
If no, go to the Medicare Information section below. Sign and date the form and return it to the address above.

Are you eligible for your employer's group health insurance coverage? Yes No
If yes, date you are eligible for your employer's coverage: _____
If no, please explain why not.

MEDICARE INFORMATION

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

Name	Medicare Card Number	Eligible for Medicare Part: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> D*	Effective Date ____/____/____
Name	Medicare Card Number	Eligible for Medicare Part: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> D*	Effective Date ____/____/____

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

PEEHIP SUBSCRIBER CERTIFICATION

I hereby affirm that I have completely read and fully understand the terms and conditions of this form. I attest that all representations made by me on this form are true and complete. I understand that any misrepresentations may result in the forfeiture of insurance coverage and that I will be personally liable for all claims related to such misrepresentation.

Retiree Signature _____ Date Signed ____/____/____

Sign, date and return the form to the address above.