

NEW ENROLLMENT AND STATUS CHANGE



Public Education Employees' Health Insurance Plan
 P. O. Box 302150 ♦ Montgomery, Alabama 36130-2150
 334.517.7000 or 877-517-0020; Fax: 334.517.7001 or 877.517.0021
 You may submit information online at <https://mso.rsa-al.gov>

Check One:

- Active Member
 Retired Member

PEEHIP Subscriber Information

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

Social Security # or PID	First Name	Middle Initial	Last Name	Date of Birth ____/____/____	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Widowed					Date Married: ____/____/____
Is your spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		Does your spouse have other health insurance coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Mailing Address			City	State	ZIP Code
Is this a change of address? <input type="checkbox"/> Yes <input type="checkbox"/> No	Home Phone ____-____-____	Cell Phone ____-____-____	Work Phone ____-____-____		
Employer/School System		Date of Employment ____/____/____		Email Address	

Have you or your spouse used tobacco products within the last 12 months?*

**This information is required for enrollment.*

- Member Spouse
 Yes No Yes No

PEEHIP Coverage Information

(You will be billed for prorata premiums or premiums that are not deducted from your payroll or retirement check.)

Section A. New Enrollment

<p style="text-align: center;">Basic Hospital/Medical <i>(PEEHIP plans are administered by Blue Cross and Blue Shield of AL)</i></p> <p>Coverage Type: <i>(Select only one of the three plans)</i></p> <p><input type="checkbox"/> PEEHIP Hospital/Medical <input type="checkbox"/> VIVA Health Plan (HMO) (Primary Care Physician _____) <input type="checkbox"/> PEEHIP Hospital/Medical Supplemental** <i>(Secondary Medical)</i> <i>**Complete Primary Insurance Information in Section D if choosing this plan. This plan is not a Medicare supplement & differs from Optional Plans.</i></p> <p><input type="checkbox"/> Single or <input type="checkbox"/> Family <i>(complete Section C)</i></p> <p>Requested Effective Date ____/____/____ <i>(required)</i></p>	<p style="text-align: center;">Optional Coverage Plans <i>(administered by Southland National)</i></p> <p>Note: <i>Optional plans must be all Single or all Family</i></p> <p>Coverage Type(s):</p> <p><input type="checkbox"/> Cancer <input type="checkbox"/> Dental <input type="checkbox"/> Indemnity <input type="checkbox"/> Vision</p> <p><input type="checkbox"/> Single or <input type="checkbox"/> Family <i>(complete Section C)</i></p> <p><i>These plans must be retained for one year until the following October 1. PEEHIP will not automatically cancel any coverage(s).</i></p> <p>Requested Effective Date ____/____/____ <i>(required)</i></p>
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Section B. PEEHIP Coverage Information (Only check boxes requiring a change to existing coverage.)

Coverage Type:	PEEHIP Hosp/Med	**PEEHIP Supplemental	VIVA HMO	Cancer	Dental	Indemnity	Vision
Change from Single to Family Coverage	<input type="checkbox"/>						
Add dependent(s) listed in Section C to Family Coverage	<input type="checkbox"/>						
Cancel Coverage	<input type="checkbox"/>						
Change from Family to Single Coverage	<input type="checkbox"/>						
Cancel dependent(s) listed in Section C from Family Coverage	<input type="checkbox"/>						

Requested Effective Date ____/____/____ *(required) QLE changes must be submitted within 45 days of the QLE.*

Reason for Status Change(s) *(check all that apply)*

Changes cannot be processed without the appropriate documentation as explained in the Member Handbook for starred () items.*

Date change occurred (Required) ____/____/____

- | | |
|---|---|
| <input type="checkbox"/> Open Enrollment – Change effective October 1st | <input type="checkbox"/> Legal custody of a child* <i>(need legal custody papers)</i> |
| <input type="checkbox"/> Adoption of a child* <i>(need adoption papers)</i> | <input type="checkbox"/> Marriage* <i>(need marriage certificate & add'l proof of marriage)</i> |
| <input type="checkbox"/> Birth of a child* <i>(need birth certificate)</i> | <input type="checkbox"/> Marriage of dependent child* <i>(need marriage certificate)</i> |
| <input type="checkbox"/> Death of spouse/dependent* <i>(need death certificate)</i> | <input type="checkbox"/> Termination of spouse/dependent employment* |
| <input type="checkbox"/> Qualifying loss of coverage* <i>(need proof of loss of coverage)</i> | <input type="checkbox"/> Commencement of spouse/dependent employment* |
| <input type="checkbox"/> Divorce/Annulment/Legal Separation* <i>(need divorce decree)</i> | <input type="checkbox"/> Spouse's employer with different open enrollment period* |
| <input type="checkbox"/> FMLA/LOA | <input type="checkbox"/> Medicare/Medicaid entitlement* <i>(need copy of card)</i> |

Note: Active members must have an IRS qualifying life event (QLE) to cancel their Hospital Medical or change their coverage outside of Open Enrollment because their premiums are pre-taxed. QLE changes must be submitted within 45 days of the QLE.

Section C. Dependent Information *(only required for family coverage)*

Social Security Number is required for all dependents. Name must be entered as it appears on the Social Security card. Appropriate eligibility documents are required for all dependents: All children – birth certificates; spouses – marriage certificate & additional current marriage document; adopted children – certificate of adoption or papers from adoption agency showing intent to adopt; step children – also required is the marriage certificate showing member's spouse is married to member; foster and other children – also required is the placement authorization signed by a judge or final court order with judge's signature and seal. *(See handbook for more detail.)*

Name of Dependent <i>(First, Middle, Last)</i>	Social Security #	Date of Birth	Relation to Subscriber	Sex	Handicapped
			<input type="checkbox"/> Spouse	<input type="checkbox"/> M <input type="checkbox"/> F	N/A
			<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"/> Yes <input type="checkbox"/> No
			<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"/> Yes <input type="checkbox"/> No
			<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"/> Yes <input type="checkbox"/> No
			<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"/> Yes <input type="checkbox"/> No
			<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"/> Yes <input type="checkbox"/> No

Section D. Primary Insurance Information** *(Must be completed if choosing PEEHIP Hospital/Medical Supplemental)*

Name of Insurance Company	Phone Number ____-____-____	Contract/Policy #	Effective Date of Coverage ____/____/____
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Section E. Other Health Insurance Information *(Must be completed for enrollment)*

Are you, your spouse, or dependent children covered under any other Hospital, Medical, Dental, or Vision plan(s)? Yes* No

*If you answered yes, you must complete a separate COORDINATION OF BENEFITS (COB) form, available at www.rsa-al.gov.

Section F. Retiree Other Employer Information *(Must be completed if you retired after September 30, 2005)*

Are you a retiree and employed by another employer? Yes* No

*If you answered yes and you retired after September 30, 2005, and became employed by another employer, you must complete a separate RETIREE EMPLOYMENT VERIFICATION form available at www.rsa-al.gov.

Section G. Medicare Information

Are you or your covered dependent(s) eligible for Medicare? Yes* No

*If you answered yes, you must complete this section and provide a copy of the Medicare card(s) to PEEHIP before your monthly retiree premium can be reduced. **Note: As a retiree or a dependent on a retired account, you MUST have BOTH Part A and Part B to have adequate coverage with PEEHIP.** If you fail to timely enroll in Part A and B, you will have a lapse in coverage if your effective date for Part A and B is after your date of retirement. You are financially liable for medical costs incurred as PEEHIP will only pay 20% of the Medicare allowable fees.

Name	Medicare Card Number
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Check the Medicare Part(s) for which you are eligible:

Part A-Effective: ____/____/____ Part B-Effective: ____/____/____ Part D**-Effective: ____/____/____

Name	Medicare Card Number
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Check the Medicare Part(s) for which you are eligible:

Part A-Effective: ____/____/____ Part B-Effective: ____/____/____ Part D**-Effective: ____/____/____

**If you are enrolled in another Medicare Part D plan (other than PEEHIP's Medicare GenerationRx), you are not eligible for the PEEHIP prescription drug plan coverage.

Section H. 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.

Member Signature _____ Date Signed ____/____/____

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