PEEHIP
OF ALABAMA

New Enrollment and Status Change

Public Education Employees' Health Insurance Plan
PO Box 302150, Montgomery, Alabama 36130-2150
877.517.0020 • 334.517.7000 • www.rsa-al.gov

Your SSN ___ ___ ___ ___ ___ ___ ___ ___ ___ **PID** _____

Check One: ❑ Active Member ❑ Retired Member You may submit information online at https://mso.rsa-al.gov.

Subscriber Information

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

Name _____
First Middle/Maiden Last

Mailing Address _____
Street or P.O. Box Apt.# City State ZIP Code

Telephone _____
Cell Phone Home Phone Work Phone

Date of Birth _____ Email Address _____

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

Is this a change of address? ❑ Yes ❑ No Sex ❑ Male ❑ Female

Marital Status ❑ Married ❑ Single ❑ Widowed ❑ Divorced ❑ Legally Separated

Employer/School System _____ Date of Employment _____

Have you or your spouse used tobacco products or an electronic smoking device within the last 12 months?
Member ❑ Yes ❑ No Spouse ❑ Yes ❑ No

Section A
New Enrollment

Administered by Southland Benefit Solutions

PEEHIP Hospital Medical Plans (select only ONE plan)

❑ PEEHIP Hospital Medical
BCBS PPO for active and non-Medicare-eligible retirees **OR** Medicare Advantage PPO Plan for Medicare-eligible retirees

❑ VIVA Health Plan
HMO for active and non-Medicare-eligible retirees

❑ PEEHIP Supplemental Medical
BCBS Secondary Medical for active and non-Medicare-eligible retirees (complete Section D)

❑ **Individual** ❑ **Family** (complete Section C)

Requested Effective Date (required) _____

Optional Coverage Plans (select one or more plans)

Plans must be retained for one year until the following October 1. PEEHIP will not automatically cancel any coverage(s).

Cancer ❑ Individual ❑ Family (complete Section C)
Dental ❑ Individual ❑ Family (complete Section C)
Indemnity ❑ Individual ❑ Family (complete Section C)
Vision ❑ Individual ❑ Family (complete Section C)

Requested Effective Date (required) _____

Section B
Status Change

Only check boxes requiring a change to **existing** coverage.

QLE change requests must be received within 45 days of the QLE.

Coverage Type	BCBS Hosp. Med	Medicare Advantage	BCBS Supplemental	VIVA HMO	Cancer	Dental	Indemnity	Vision
Change from Individual to **Family** Coverage	❑	❑	❑	❑	❑	❑	❑	❑
Add dependent(s) listed in Section C to Family Coverage	❑	❑	❑	❑	❑	❑	❑	❑
Cancel Coverage	❑	❑	❑	❑	❑	❑	❑	❑
Change from Family to **Individual** Coverage	❑	❑	❑	❑	❑	❑	❑	❑
Cancel dependent(s) listed in Section C from Family Coverage	❑	❑	❑	❑	❑	❑	❑	❑

Requested Effective Date (required) _____

Reason for Status Change(s)

Check all that apply

QLE change requests must be received within 45 days of the QLE.

Date Change Occurred (required) _____

Members must have an IRS qualifying life event (QLE) to change their coverage outside of Open Enrollment because their premiums are pre-taxed.
For starred (*) items, changes cannot be processed without the appropriate documentation as explained in the Member Handbook.

❑ Open Enrollment - **Change effective October 1**	❑ Legal custody of a child* (legal custody papers)
❑ Adoption of a child* (adoption papers)	❑ Marriage* (marriage certificate and additional proof of marriage)
❑ Birth of a child* (birth certificate)	❑ Marriage of dependent child* (marriage certificate)
❑ Death of spouse/dependent	❑ Termination of member/spouse/dependent employment*
❑ FMLA/LOA	❑ Commencement of spouse/dependent employment*
❑ Medicare/Medicaid entitlement (copy of card to cancel coverage)	❑ Enrolling in PEEHIP Supplemental Medical Plan
❑ Loss of eligibility for other health coverage* (proof of loss of coverage) (due to divorce/legal separation, job change/loss, retirement without benefits)	❑ Spouse's employer with different open enrollment period* (to cancel Hospital Medical coverage only)

New Enrollment and Status Change

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

Name _____ **SSN** ___ ___ ___ ___ ___ ___ ___ ___ ___

Section C
Dependent Information

Only required for family coverage

Social Security Number and copy of Social Security card 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 certificates and 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 details.)

Name of Dependent First, Middle, Last	Social Security Number	Date of Birth	Relation to Subscriber	Sex	Incapacitated
			❑ Spouse Date Married:	❑ M ❑ F	N/A
			❑ Biological ❑ Adopted ❑ Step ❑ Other	❑ M ❑ F	❑ Yes ❑ No
			❑ Biological ❑ Adopted ❑ Step ❑ Other	❑ M ❑ F	❑ Yes ❑ No
			❑ Biological ❑ Adopted ❑ Step ❑ Other	❑ M ❑ F	❑ Yes ❑ No
			❑ Biological ❑ Adopted ❑ Step ❑ Other	❑ M ❑ F	❑ Yes ❑ No
			❑ Biological ❑ Adopted ❑ Step ❑ Other	❑ M ❑ F	❑ Yes ❑ No

Section D
Primary Insurance Information

Must be completed if choosing PEEHIP Supplemental Medical

Name of Insurance Company _____ Telephone Number _____

Contract/Policy Number _____ Effective Date of Coverage _____

Section E
Additional (Non-PEEHIP) 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 form, available at 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 rsa-al.gov.

Section G
Medicare Information

Must be completed if you or your dependents are eligible for Medicare

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.

As a retiree or a dependent on a retired account, you MUST have BOTH Part A and Part B to have coverage with PEEHIP. If you do not have both Part A and Part B, you will not be eligible for PEEHIP's Medicare Advantage Plan and will not have hospital medical or prescription drug coverage with PEEHIP.

Name _____ Medicare Card Number _____

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

❑ Part A Effective _____ ❑ Part B Effective _____ ❑ Part D** Effective _____

Name _____ Medicare Card Number _____

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 group part D plan), 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.

Sign Here ➔ Subscriber **Your Signature** _____ **Date** _____