

## INSTRUCTIONS FOR COMPLETING THE ACTIVE NOTICE OF ELECTION (NOE)

### IF COMPLETING BY HAND, USE BLACK INK

*You must also complete a Tobacco Certification form within 31 days of your hire date and whenever the status of tobacco use changes for you or a dependent covered under your health insurance.*

**ACTION:** Indicate type of action. MoneyPlu\$: Premiums for health, dental, vision and Optional Life are deducted on a pretax basis unless refused. There is an administrative fee for the pretax deductions. Pretax MoneyPlu\$ 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.

**Block 20. MEDICARE:** List yourself and any other persons to be covered who are eligible for Part A and/or Part B of Medicare.

**Block 21. If you and/or your dependents have had other coverage with another carrier within 62 days of this request, please attach a copy of your certificate of health coverage. This will ensure proper credit for any pre-existing condition exclusions.** If you checked "Yes," list all dependents with other group coverage. If you are submitting an update because a dependent no longer has other group health coverage, check "No" and enter the date coverage ended.

**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 22. 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 (every two years) 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 23. 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 (every two years) 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 24. DENTAL PLUS:** You must enroll in the State Dental Plan to enroll in Dental Plus. You must also cover the same family members under both plans.

**Block 25. 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 Employee Insurance Program 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 the Employee Insurance Program 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 26. DEPENDENT LIFE—SPOUSE:** Before making a selection, refer to the detailed instructions provided by your employer.

To select coverage, check "Coverage Level" and enter the 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 27. OPTIONAL LIFE:** Before making a selection, refer to the detailed instructions provided by your employer.

To select coverage, check "Coverage Level" and enter the 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 MoneyPlu\$ pretax premium feature, you must wait until the next enrollment period or within 31 days of a special eligibility situation.

**Block 28. 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 29. VISION CARE:** Before making a selection, refer to the plan description provided by your employer.

**Block 30. 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 31. 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 EIP-covered employer, check "Yes."

A child younger than 26 is eligible for health, dental and vision coverage unless he is eligible for employer-sponsored group 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.

**CERTIFICATION AND AUTHORIZATION:** 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 all supporting documentation before submitting it to the **Employee Insurance Program at P.O. Box 11661 Columbia, SC 29211-1661**.