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.

ACTIVE EMPLOYEE NOTICE OF ELECTION (NOE)

SOUTH CAROLINA BUDGET AND CONTROL BOARD
EMPLOYEE INSURANCE PROGRAM (EIP)

Clear Form

A
See Instructions - If Completing By Hand Use Black Ink

ACTION

Select One:	Type of Change	BA Use Only	MoneyPlu$ Pretax Premiums
☐ New Hire ☐ Transfer ☐ Change	☐ Enrollment Other *(specify)* _____ Date of Change Event: _____	Effective Date: _____ ☐ Permanent P/T EE *(20 hrs.)* Group ID #: _____ Group Name: _____	☐ Refuse ☐ Yes

ENROLLEE INFO

1. Social Security Number (SSN)	2. Last Name	3. Suffix	4. First Name	5. M.I.	6. Date of Birth MM/DD/YYYY

7. Sex	8. Marital Status	9. Home Phone #	10. Work Phone #	11. E-mail Address
☐ M ☐ F	☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated	( )	( )	

12. Mailing Address	13. Apt.	14. City	15. State	16. Zip Code	17. County Code	18. Annual Salary	19. Date of Hire MM/DD/YYYY

MEDICARE & OTHER COVERAGE

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

Name	Medicare #	Eligible Due To	Effective Date Part A MM/DD/YYYY	Effective Date Part B MM/DD/YYYY
		☐ Age ☐ Disability ☐ Renal Disease		
		☐ Age ☐ Disability ☐ Renal Disease		

21. Do you or any of your dependent(s) have other health coverage? ☐ YES ☐ NO Does this coverage include prescription drug benefits? ☐ YES ☐ NO

Dependent Name	Insurance Company	Policy Holder Date of Birth	Effective Date of Policy	Termination Date *(if Applicable)*

COVERAGE

22. HEALTH PLAN *(Refuse or select one plan and one level of coverage)*

PLAN
☐ Refuse ☐ HMO_____ *Name of HMO*
☐ Standard ☐ Savings
Basic Life and Basic Long Term Disability included automatically with health plan

COVERAGE LEVEL
☐ Employee ☐ Employee/Child(ren)
☐ Employee/Spouse ☐ Family

23. STATE DENTAL PLAN *(Select One)*
☐ Refuse ☐ Employee/Spouse
☐ Employee ☐ Employee/Child(ren)
☐ Family

24. DENTAL PLUS *(Select One)*
☐ Refuse
☐ Yes

25. DEPENDENT LIFE - Child(ren) *(Select One)*
☐ Refuse
☐ $15,000

26. DEPENDENT LIFE - Spouse *(Select One)*
☐ Refuse ☐ Coverage Level
$_____
(Must be in increments of $10,000)

27. OPTIONAL LIFE *(Select One)*
☐ Refuse ☐ Coverage Level
$_____
(Must be in increments of $10,000)

28. SUPPLEMENTAL LTD *(Select One)*
☐ Refuse
☐ Plan One - *90-day benefit waiting period*
☐ Plan Two - *180-day benefit waiting period*

29. VISION CARE *(Select One)*
☐ Refuse ☐ Employee/Spouse
☐ Employee ☐ Employee/Child(ren)
☐ Family

BENEFICIARIES

In blocks 30 and 31, if there are additional beneficiaries or dependents, list on separate sheet, signed and dated by employee.

30. Basic Life/Optional Life *(Select one or both)*	SSN#	Last Name	First Name	Relationship	Date of Birth MM/DD/YYYY	Primary or Contingent?
☐ Basic Life ☐ Optional Life						☐ Primary ☐ Contingent
☐ Basic Life ☐ Optional Life						☐ Primary ☐ Contingent

If beneficiary is an estate or trust, complete the following:
Estate/Trust_____ Address_____ If Trust, Date Signed_____

DEPENDENTS

31. Always list spouse. List eligible children to be covered. If they are not listed, they will not be covered. For a child age 19-24 to be eligible for Dependent Life-Child coverage, submit a Student Certification Form or Incapacitated Child Certification Form.

Add (A) or Delete (D)	Dependent SSN#	Last Name	First Name	Sex M/F	Relationship	Date of Birth MM/DD/YYYY	Indicate Special Status
	Spouse						Is spouse employed with, or retired from, an EIP-covered employer? ☐ Yes ☐ No
	Child						☐ Full-time Student ☐ Incapacitated
	Child						☐ Full-time Student ☐ Incapacitated
	Child						☐ Full-time Student ☐ Incapacitated

CERTIFICATION & AUTHORIZATION

32. CERTIFICATION: I have read this NOE and made authorizations herein and selected the coverage noted. I have provided Social Security numbers and documentation establishing my dependent(s)' eligibility for the plan(s) selected. I certify that any child enrolled in Dependent Life/Child insurance is eligible according to the requirements on the reverse of this NOE. I also understand that proof of eligibility (at the time of enrollment and at the time of the claim) will be required before any Dependent Life/Child insurance claim is paid. I understand that unless otherwise provided in the Plan, I may cancel coverage for me or my dependent(s) only during an open enrollment period (every two years). Should I refuse any coverage or fail to enroll all eligible dependents when first eligible, I and/or all eligible dependents may only enroll during an open enrollment period (every two years) unless otherwise provided by the Plan. I understand and agree that all selected plans will not be effective unless and until the NOE is approved. I understand that the State reserves the right to alter benefits or premiums at any time to preserve the financial stability of the Plan. I further acknowledge that the eligibility status of any covered individual is subject to audit at any time.

AUTHORIZATION: I hereby authorize my employer to deduct from my salary premiums necessary to pay for all plans selected and verify my salary for enrollment. I authorize any healthcare provider, prescription drug dispenser and claims administrator to release any information necessary to evaluate, administer and process claims for any benefits.

DISCLAIMER: THE LANGUAGE USED IN THIS DOCUMENT DOES NOT CREATE AN EMPLOYMENT CONTRACT BETWEEN THE EMPLOYEE AND THE AGENCY. THIS DOCUMENT DOES NOT CREATE ANY CONTRACTUAL RIGHTS OR ENTITLEMENTS. THE AGENCY RESERVES THE RIGHT TO REVISE THE CONTENT OF THIS DOCUMENT IN WHOLE OR IN PART. NO PROMISES OR ASSURANCES, WHETHER WRITTEN OR ORAL, WHICH ARE CONTRARY TO OR INCONSISTENT WITH THE TERMS OF THIS PARAGRAPH CREATE ANY CONTRACT OF EMPLOYMENT.

Employee Signature _____ Date _____

33. I hereby attest the employee meets eligibility requirements, proper premiums are being collected, this form is complete and accurate and all required documentation is attached to process NOE form.

Benefits Administrator Signature _____ Date _____