*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<br>☐ Transfer<br>☐ Change | ☐ Enrollment Other *(specify)* _____<br>☐ Address Date of Change Event: _____ | Effective Date: _____ ☐ Permanent P/T EE *(20 hrs.)*<br>Group ID #: _____<br>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**

**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 organization or trust, complete the following:**
Organization/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.**

| 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 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.

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 _____

# 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 dependents to be covered for Dependent Life Insurance, they must be listed in **Block 30**.

**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:** 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."

Legal documentation is required for all children other than natural children (i.e., grandchild, niece, nephew, foster child, brother, sister, adopted child). For a child age 19-24 to be eligible for coverage, he must be a full-time student or incapacitated (documentation required). Full-time student status and continued eligibility may be audited. 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.**