

**SOUTH CAROLINA STATE BUDGET AND CONTROL BOARD
EMPLOYEE INSURANCE PROGRAM (EIP)
COBRA NOTICE OF ELECTION**

C
SEE INSTRUCTIONS
IF COMPLETING BY HAND
USE BLACK INK

ELIG.	Select ONE: <input type="checkbox"/> Left Employment, RIF - Eligible for 18 Months (includes employee, spouse and dependents) <input type="checkbox"/> Disabled, Provide Copy of Social Security Award Letter - Eligible for 29 Months <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Dependent Child Eligibility Ended - Eligible for 36 Months				Sponsoring Employee/Retiree Social Security Number _____		Date of Occurrence: Month _____ Date _____ Year _____		
	Verification of Eligibility (required of subscribers from entities other than state agencies and school districts) Benefits Administrator Signature _____ Employer ID _____								
ACTION	Select ONE of the Following: <input type="checkbox"/> New Subscriber <input type="checkbox"/> Termination <input type="checkbox"/> Address Change <input type="checkbox"/> Change (Specify) _____ Date of Occurrence _____ SSN Change - Incorrect # _____ Name Change - Prior Name _____ (Attach Copy of Social Security ID Card)					EIP USE ONLY			
						Employer ID _____ Effective Date _____ Group ID# _____			
ENROLLEE INFO	1. Social Security Number _____		2. Last Name _____		3. Suffix _____	4. First Name _____		5. M.I. _____	6. Date of Birth MM/DD/YYYY _____
	7. Sex <input type="checkbox"/> M <input type="checkbox"/> F	8. Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated		9. Home Phone # () _____		10. E-mail Address _____			
	11. Mailing Address _____			12. Apt. _____	13. City _____		14. State _____	15. Zip Code _____	16. County Code _____
COVERAGE	It is your responsibility to select the appropriate insurance coverage. See the benefits options before making your selection. Select one health plan and dental plan(s). To refuse coverage, mark "REFUSE".								
	17. HEALTH PLAN (Refuse or select one plan and one category) PLAN <input type="checkbox"/> Standard <input type="checkbox"/> HMO _____ CATEGORY <input type="checkbox"/> Savings (Non-Medicare) <small>Name of HMO</small> <input type="checkbox"/> Enrollee <input type="checkbox"/> Enrollee/Child(ren) <input type="checkbox"/> Refuse All Above Health Plans <input type="checkbox"/> Enrollee/Spouse <input type="checkbox"/> Family <input type="checkbox"/> Child Only Through Age 18				18. STATE DENTAL PLAN (Select One) <input type="checkbox"/> Enrollee/Spouse <input type="checkbox"/> Refuse <input type="checkbox"/> Enrollee/Child(ren) <input type="checkbox"/> Enrollee <input type="checkbox"/> Family <input type="checkbox"/> Child Only Through Age 18			19. DENTAL PLUS (Select One) <input type="checkbox"/> Yes <input type="checkbox"/> Refuse (You must be enrolled in the State Dental Plan to elect Dental Plus. If no election is indicated for Dental Plus, you will not be enrolled for this coverage.)	
MEDICARE AND OTHER COVERAGE	LIST BELOW, YOURSELF AND ANY OTHER PERSONS TO BE COVERED WHO ARE ELIGIBLE FOR PART A AND/OR PART B OF MEDICARE.								
	20. NAME		MEDICARE#		ENTITLED DUE TO		EFFECTIVE DATE		
					<input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> Renal Disease		PART A MM/DD/YYYY	PART B MM/DD/YYYY	
					<input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> Renal Disease				
Do you or any of your dependent(s) have other health coverage? <input type="checkbox"/> YES <input type="checkbox"/> NO Does this coverage include pharmacy benefits? <input type="checkbox"/> YES <input type="checkbox"/> NO 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 conditions, if applicable.									
21. DEPENDENT NAME		INSURANCE COMPANY		POLICY HOLDER DATE OF BIRTH		EFFECTIVE DATE OF POLICY		TERMINATION DATE	
DEPENDENT INFO.	List spouse and eligible children to be covered under health and/or dental plan(s). If they are not listed, they will not be covered.								
	Add (A) or Delete (D)	22. Dependent SSN#	Last Name	First Name	SEX M/F	Relationship	Date of Birth MM/DD/YYYY	Indicate Status	
		Spouse						Spouse employed by state covered entity <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Child						<input type="checkbox"/> Full-time student <input type="checkbox"/> Incapacitated	
		Child						<input type="checkbox"/> Full-time student <input type="checkbox"/> Incapacitated	
	Child						<input type="checkbox"/> Full-time student <input type="checkbox"/> Incapacitated		
CERTIFICATION & AUTHORIZATION	23. 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 understand that it is my sole responsibility to pay all required								
	premiums for all plans selected. Failure to pay the required premiums by the due dates will result in cancellation of coverage. 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 THE PARAGRAPH CREATE ANY CONTRACT OF EMPLOYMENT.								
Enrollee Signature _____ Date _____									

COBRA NOTICE OF ELECTION FORM INSTRUCTIONS

ELIGIBILITY: Select one to indicate eligibility if you are enrolling under COBRA for the first time. New COBRA enrollees should also indicate date of occurrence of the qualifying event (i.e. date left employment, disability approved by Social Security, divorce, child ineligible, etc.). If you are already enrolled under COBRA and are making a change, skip to the Action section.

ACTION: If you are enrolling under COBRA for the first time, check “new subscriber.” If you are already enrolled under COBRA and making a change, check “change” and indicate the type of change and date of occurrence. If you wish to terminate your COBRA coverage, check “termination.”

ENROLLEE INFORMATION: Blocks 1-16 must be completed for all transactions including terminations. **In block 16**, indicate the county code of your mailing address. If coverage is for dependent children only, enrollee information should be for the youngest child or, if applicable, for a child covered under Medicare; additional children should be indicated as dependents in **block 22**.

LIST OF CODE NUMBERS OF S.C. COUNTIES:

01 Abbeville	11 Cherokee	21 Florence	31 Lee	41 Saluda
02 Aiken	12 Chester	22 Georgetown	32 Lexington	42 Spartanburg
03 Allendale	13 Chesterfield	23 Greenville	33 McCormick	43 Sumter
04 Anderson	14 Clarendon	24 Greenwood	34 Marion	44 Union
05 Bamberg	15 Colleton	25 Hampton	35 Marlboro	45 Williamsburg
06 Barnwell	16 Darlington	26 Horry	36 Newberry	46 York
07 Beaufort	17 Dillon	27 Jasper	37 Oconee	99 Out of S.C.
08 Berkeley	18 Dorchester	28 Kershaw	38 Orangeburg	
09 Calhoun	19 Edgefield	29 Lancaster	39 Pickens	
10 Charleston	20 Fairfield	30 Laurens	40 Richland	

COVERAGE. ALTERATIONS IN THIS SECTION ARE NOT ALLOWED:

In block 17, select one health plan and one level of coverage or check “refuse all above health plans”. Changes from one health plan to another are allowed only during designated enrollment periods (exceptions: changes upon entitlement to Medicare; and if HMO enrollees move out of the service areas). MUSC Options and Savings Plan are available only to non-Medicare enrollees and dependents. If you refuse health coverage and enroll under dental, you can enroll yourself and all eligible dependents within 31 days of a special eligibility situation or during the next designated open enrollment period if applicable.

In block 18, indicate level of dental coverage or “refuse”. If you refuse dental coverage and enroll under health you can enroll yourself and all eligible dependents within 31 days of a special eligibility situation or during the next designated open enrollment period if applicable.

In block 19, indicate Dental Plus (“yes” to enroll or “refuse”). You must enroll in basic dental coverage to enroll in Dental Plus. Coverage level in Dental Plus must equal coverage level in basic dental plan.

MEDICARE AND OTHER COVERAGE INFORMATION: In block 20, list yourself and any other persons to be covered who are eligible for Part A and/or Part B of Medicare.

In block 21, 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 list the termination date of the policy.

DEPENDENT INFORMATION: In block 22, list spouse and indicate if spouse is a covered employee or retiree of a state covered entity. List all dependents to be covered under health and/or dental. If they are not listed, they will not be covered. Legal documentation is required for an ex-spouse and all children other than natural children (i.e., grandchild, niece, nephew, foster child, brother, sister or adopted child). In order for children age 19 through 24 to be considered eligible for coverage, the dependent must be a full-time student or incapacitated (documentation required for both). Full-time student status is subject to audits. Misstatements on the NOE may result in coverage termination and recoupment of benefits paid on behalf of the ineligible dependent.

CERTIFICATION AND AUTHORIZATION: Read block 23 carefully, sign and date form.

Send the original form to the Employee Insurance Program, P.O. Box 11661, Columbia, SC 29211. Keep a copy for your records.