You must also complete a Tobacco Certification form within 30 days of enrolling in health coverage and whenever the status of tobacco use changes for you or a dependent covered under your health insurance.

PART-TIME NOTICE OF ELECTION (NOE)

SOUTH CAROLINA PUBLIC EMPLOYEE BENEFIT AUTHORITY
INSURANCE BENEFITS

Clear Form

P See Instructions - If Completing By Hand Use Black Ink

ACTION

Select One:
- ☐ New Hire/ Newly Eligible
- ☐ Transfer
- ☐ Change

☐ Other *(Specify)* _____
Date of Change Event _____
SSN Change - Incorrect # _____
(Attach Copy of Social Security Card)
Name Change - Prior Name _____

BA Use Only
Effective Date: _____
Group ID#: _____
Group Name: _____

MoneyPlus Pretax Premiums
☐ Refuse ☐ Yes

ENROLLEE INFO

1. Soc. Sec. # (SSN) BIN #	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

COVERAGE

It is your responsibility to select the appropriate insurance coverage. See the instructions before making your selections. Alterations in this section are not allowed.

20. CATEGORY *(Number of hours worked - Part-time teachers only)* ☐ 15-19 hours ☐ 20-24 hours ☐ 25-29 hours

21. HEALTH PLAN *(Basic Life/Basic LTD not provided with health coverage) (Refuse or select **one** plan and **one** level of coverage)*

PLAN
- ☐ Refuse ☐ TRICARE Supplement
- ☐ Standard
- ☐ Savings *(Not Medicare-eligible)*

COVERAGE LEVEL *(Select One)*
- ☐ Employee ☐ Family
- ☐ Employee/Child(ren)
- ☐ Employee/Spouse

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

23. DENTAL PLUS *(Select One)*
- ☐ Refuse
- ☐ Yes

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

MEDICARE

25. 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		
		☐ Age ☐ Disability ☐ Renal Disease		
		☐ Age ☐ Disability ☐ Renal Disease		

DEPENDENTS

26. Always list spouse. List eligible children to be covered. If they are not listed, they will not be covered. For children older than 25 to be eligible for coverage, submit an 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						Does PEBA Insurance Benefits already cover your spouse? ☐ Yes ☐ No
	Child						☐ Incapacitated
	Child						☐ Incapacitated
	Child						☐ Incapacitated

CERTIFICATION & AUTHORIZATION

27. 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. 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 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 _____

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

Benefits Administrator Signature _____ Date _____

INSTRUCTIONS FOR COMPLETING THE PART-TIME NOTICE OF ELECTION (NOE)

IF COMPLETING BY HAND, USE BLACK INK

You must also complete a Tobacco Certification form within 30 days of enrolling in health coverage and whenever the status of tobacco use changes for you or a dependent covered under your health insurance.

ACTION: Indicate type of action. MoneyPlus: Premiums for health, dental, and vision are deducted on a pretax basis unless refused. There is an administrative fee for the pretax deductions. MoneyPlus changes must be made during enrollment or within 30 days of a qualifying change in status event.

ENROLLEE INFORMATION: Blocks 1-19 must be completed for all transactions, including a refusal of coverage.

COUNTY CODES:

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 (such as mark-throughs or white out) in this section are not allowed.

Block 20. Select a category based on number of hours worked. If working 30 or more hours per week, complete the Active NOE.

Block 21. 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 apply for coverage for yourself and/or your dependent(s) only during an open enrollment period or within 30 days of a special eligibility situation. Basic Life Insurance and Basic Long Term Disability are not provided with health coverage. To select a health plan, check only one block. 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 26**, and the appropriate level of coverage must be selected.

Block 22. DENTAL: If you refuse dental when first eligible, you can enroll yourself and your dependent(s) only during an open enrollment period in an odd-numbered year or within 30 days of a special eligibility situation. For dependents to be covered, they must be listed in **Block 26** and the appropriate level of coverage must be selected.

Block 23. 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 24. VISION CARE: Before making a selection, refer to the plan description provided by your employer.

Block 25. MEDICARE: List yourself and any other persons to be covered who are eligible for Part A and /or Part B of Medicare.

Block 26. DEPENDENT INFORMATION: 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 not an employee or retiree of a PEBA Insurance Benefits-covered employer (an employer that participates in the State of South Carolina Insurance Benefits Program. If spouse is an employee or retiree of a PEBA Insurance Benefits-covered employer, check “Yes.”

A child younger than 26 is eligible for health, dental and vision 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:
Block 27: Form must be signed and dated by employee within 30 days of hire or the qualifying event.

Block 28: The benefits administrator must sign and date the form and attach all documentation before submitting it to PEBA Insurance Benefits.