

**To:** Individuals eligible for retirement

**From:** S.C. Public Employee Benefit Authority

**RE:** Retiree insurance benefits for employee and their eligible dependents

---

Before you retire, you need to consider how retirement may affect one of your most important assets, your insurance coverage. Since you will be a retiree of a participating employer (state agency, public school district, higher education institution or local subdivision), you may be eligible to:

- Continue or enroll in health insurance with prescription drug coverage. When you become eligible for Medicare, you will be able to change to a Medicare supplemental plan.
- Continue or enroll in dental insurance.
- Convert your \$3,000 Basic Life insurance policy to an individual policy.
- Continue your Optional Life insurance or convert it to an individual policy.
- Convert any Dependent Life insurance you have to an individual policy.
- Continue Supplemental Disability Insurance (in certain instances).
- Continue or enroll in the State Vision Plan.

This packet contains the following information to help you make informed decisions about your insurance when you do retire:

- A description of the retiree insurance eligibility guidelines (these guidelines are also included in your *Insurance Benefits Guide*);
- Information on how your prescription drug coverage when you enroll as a retiree;
- A Retiree Notice of Election (enrollment form) and directions on how to complete it;
- An Employment Verification Record form to help confirm your eligibility for state retirement insurance benefits; and
- Information on how to continue (portability) your life insurance or convert it to an individual policy, applications and an explanation of “portability” vs. “conversion.”

You must complete and submit the Retiree Notice of Election and any other applications in this packet within 31 days of your retirement date. The completed forms should be submitted to PEBA if you work for a state agency, public school district or higher education institution. Forms may be submitted to your employer’s benefits office if you work for a local subdivision.

Please refer to the Retirement/Disability Retirement chapter of the *Insurance Benefits Guide* for a detailed description of benefits for retirees. If you are eligible for Medicare, please also refer to the *When you Become Eligible for Medicare* guide.

# Retiree insurance eligibility and funding

## Eligibility

Eligibility for retiree group insurance is not the same as eligibility for retirement. It is always a good idea to check with your benefits administrator to find out if you are eligible for retiree group insurance before you retire.

Generally, you may be eligible for health, dental and vision coverage in retirement if you meet these criteria:

- You retire from an employer that participates in the state insurance program.
- You are eligible to retire when you leave employment.
- You are approved for disability through one of PEBA's defined benefit plans (South Carolina Retirement System, Police Officers Retirement System, General Assembly Retirement System or Judges and Solicitors Retirement System).
- You are approved for disability through The Standard for Basic Long Term disability and/or Supplemental Long Term Disability if you participate in the State Optional Retirement Program or are an employee of a local subdivision that is not covered under PEBA's retirement plans.

Regardless of how or when you qualify for retirement, to be eligible for retiree group insurance, your last five years of employment must be served consecutively in a full-time, permanent position with an employer that participates in the state insurance program. If there is a break in your last five years of employment because you were on unpaid leave or were receiving Workers' Compensation benefits, please contact PEBA before making final arrangements for retirement.

## Teacher and Employee Retention Incentive (TERI) program

If you are a TERI participant in a permanent, full-time position, your insurance benefits as an active employee continue. When your TERI employment ends, you will need to apply for continuation of your insurance benefits as a retiree (if eligible) within 31 days of your date of termination. Your service as a TERI participant in a full-time, permanent position may be applied toward retiree insurance eligibility

## Funding

As an active employee, your employer pays part of the cost of your health and dental insurance. When you retire, the amount your employer contributes to your retiree insurance premiums is based on several factors, including your number of years of earned service credit, and the type of agency from which you retired. Another important factor in the funding equation is your date of hire. New retiree insurance eligibility guidelines were established by S.C. Code Ann. Section 1-11-730 (B). These guidelines, which help determine the amount your employer contributes to your premiums, apply to new employees hired on or after May 2, 2008.

## Employees hired before May 2, 2008

If you participate in the South Carolina Retirement System (SCRS) or the State Optional Retirement Program (State ORP), the following guidelines will determine how your premiums are funded. If you participate in the Police Officers Retirement System, General Assembly Retirement System or Judges and Solicitors Retirement System, contact your benefits administrator for premium information. Local subdivision employees should contact their benefits office for funding information.

Age	Established SCRS/ State ORP service credit	Earned service credit <sup>1</sup> with participating employer	Premiums
Any	28 years	10 years	Retiree pays retiree share only
60 and older	10 years	10 years	Retiree pays retiree share only
60 and older	20 years (left employment before eligible to retire)	20 years	Retiree pays retiree share only (coverage begins when eligible for retirement)
55 to 60	25 years (does not apply to State ORP participants)	10 years	Retiree pays retiree share and employer share until age 60 or when 28 years of service would have been earned. Afterward, retiree pays retiree share only
Any if approved for disability	5 years	5 but fewer than 10 years	Retiree pays retiree share and employer share

## Employees hired on or after May 2, 2008

Age	Established SCRS/ State ORP service credit	Earned service credit <sup>1</sup> with participating employer	Premiums
Any	28 years	25 years	Retiree pays retiree share only
60 and older (or approved for disability)	At least 15 years	15 years	Retiree pays retiree share and 50 percent of employer share
60 and older (or approved for disability)	At least 5 years	5 years	Retiree pays retiree share and employer share

<sup>1</sup>The following types of service do not count toward your earned service credit requirement for insurance eligibility: non-qualified, federal, military, out-of-state employment, educational service, leave of absence, unused sick leave or service with employers that do not participate in the state insurance program.

## Your prescription drug coverage when you enroll in the State Health Plan as a retiree

1. It is important to send your Retiree Notice of Election form to PEBA at least 30 days before your retirement date. Once the Retiree Notice of Election form is processed by PEBA, it may take up to 10 business days to activate your prescription benefits as a retiree.
2. PEBA automatically enrolls Medicare-eligible retirees and their Medicare-eligible dependents in the State Health Plan (SHP) Medicare Prescription Drug Program. This drug program is a Medicare Part D prescription drug program. PEBA does not charge an additional premium for prescription drug coverage.
3. New prescription ID cards will be sent to each SHP Medicare Prescription Drug Program participant. If you (or your dependent) are not eligible for Medicare, you will not receive a new prescription ID card.
4. If you (or your dependent) are eligible for Medicare, you will receive a letter from Express Scripts, the SHP pharmacy benefits manager, when your prescription drug coverage is activated. If you do not want to remain enrolled in the SHP Medicare Prescription Drug Program, you may opt out by calling Express Scripts by the deadline in the letter. Typically, a member has 21 days to opt out. If a member opts out of the SHP Medicare Prescription Drug Program, he will automatically be enrolled in the non-Medicare prescription drug program offered by PEBA.
5. If you enroll in prescription drug coverage with another Medicare Part D plan (not the State Health Plan), you will lose all prescription drug benefits with the State Health Plan. Your monthly health premiums will remain the same.
6. For most members, the SHP Medicare Prescription Drug Program is more advantageous than the non-Medicare drug program offered to active employees.

## Advantages of SHP Medicare Prescription Drug Program

The SHP Medicare Prescription Drug Program offers additional benefits to members. Some of the additional benefits are:

- **Lower drug costs:** The formulary, the list of drugs covered, and the tier ratings for the non-Medicare plan are determined by PEBA; while the formulary and tier ratings for the Medicare Part D plan are determined by the Centers for Medicare and Medicaid Services (CMS). In some cases, CMS tier ratings for some drugs may be lower.
- **Prorated copayments:** Copayments for the non-Medicare plan are based on a 30-day supply of the drug. Copayments for the SHP Medicare Prescription Drug Program are prorated based on the number of days the prescription will cover. For example, if a member is prescribed a Tier 2 medication and the doctor writes the prescription for 10 tablets to be taken for 10 days, the copayment is reduced to reflect a 10-day supply (\$12.67) instead of a 30-day supply (\$38).
- **Larger formulary:** Members enrolled in the Medicare Part D plan have access to all drugs available on the non-Medicare plan **plus** any additional drugs covered by CMS. Members are not losing access to any drugs by enrolling in the Medicare Part D plan.
- **Dispense as Written Protection:** If a generic equivalent is available, but the member's physician wants the member to take the brand name, the member enrolled in the SHP Medicare Prescription Drug Program is not required to pay-the-difference in most cases as he would if he were enrolled in the non-Medicare prescription drug plan. The member will pay the brand copay. For example, Diovan HCT has a generic equivalent. As of January 1, 2015, the brand-name Diovan HCT is a Tier 3 (\$63) drug on the SHP Medicare Prescription Drug Program formulary. A member who is not enrolled in the SHP Medicare Prescription Drug Program would pay-the-difference, and the drug would cost the member \$155.
- **Low-Income Subsidies:** Some people with limited resources and income may be able to get extra help to pay for the costs—monthly premiums, annual deductibles and prescription copayments—related to a Medicare prescription drug plan. The member's resources must be limited to \$13,440 for an individual or \$26,860 for a married couple living together. If you would like to find out if you are eligible for extra help, contact the Social Security Administration.

### Reasons a member might consider opting out of the Medicare Part D plan:

- **Manufacturer discount cards/programs:** Under CMS regulations, manufacturer coupons cannot be used with a Medicare Part D prescription drug plan. If you use coupons or discount cards to obtain prescriptions, you should determine if the additional benefits of the SHP Medicare Prescription Drug Program offset the savings of any coupons or discount cards.
- **TRICARE members:** Prescription benefits offered through TRICARE and TRICARE for Life do not coordinate with Medicare Part D plans. The SHP Medicare Prescription Drug Program is a Part D plan. If you would like to use both prescription drug plans, you must opt out of the SHP Medicare Prescription Drug Program. You will then be enrolled in PEBA's non-Medicare prescription drug program.
- **IRMAA (Income Related Monthly Adjustment Amounts):** High-income earners enrolled in a Medicare Part D plan may pay a monthly fee to the Social Security Administration. Check with Social Security for information about income thresholds and monthly adjustments ([www.socialsecurity.gov/online/ssa-44.pdf](http://www.socialsecurity.gov/online/ssa-44.pdf)). If you will pay an IRMAA fee, you should determine if the additional benefits of the Medicare Part D plan outweigh the monthly adjustment.

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

## RETIREE NOTICE OF ELECTION (NOE) SOUTH CAROLINA PUBLIC EMPLOYEE BENEFIT AUTHORITY INSURANCE BENEFITS



See Instructions - If Completing By Hand Use Black Ink

<b>ELIGIBILITY</b>	<b>Select</b> <input type="checkbox"/> Regular Retiree <input type="checkbox"/> Disability Retiree <input type="checkbox"/> Police Retiree	Indicate Record of Service <i>(Attach Employment Record)</i>  ____ Yrs. ____ Mos. ____ Days	<b>Select ONE (If Applicable)</b> <input type="checkbox"/> 5-10 Year Retiree <input type="checkbox"/> Age 55/25 Years Retiree Ending Date _____ <input type="checkbox"/> TERI Retiree Ending Date _____
--------------------	---	--	--

**Verification of eligibility** (required of retirees from employers other than state agencies and school districts)  
**Benefits Administrator Signature** \_\_\_\_\_ **Employer ID** \_\_\_\_\_

<b>ACTION</b>	<b>PEBA INSURANCE BENEFITS USE ONLY</b>
<b>Select ONE:</b> <input type="checkbox"/> New Subscriber - Date of Retirement _____ <input type="checkbox"/> Termination <input type="checkbox"/> Previously enrolled as a Retiree - returning to Retiree status <input type="checkbox"/> Change (Specify) _____ SSN Change - Incorrect # _____ Date of Change Event _____ <i>(Attach Copy of Social Security Card)</i>	Employer ID _____ Effective Date _____ Group ID # _____

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 <input type="checkbox"/> M <input type="checkbox"/> F	8. Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married		9. Home Phone # ( )		10. E-mail Address	
11. Mailing Address			12. Apt.	13. City	14. State	15. Zip Code
16. County Code						

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

<b>COVERAGE</b>	<b>17. HEALTH PLAN</b> (Refuse or select one plan and one level of coverage) <b>PLAN</b> <input type="checkbox"/> Refuse <input type="checkbox"/> Medicare Supplement <input type="checkbox"/> Retiree <input type="checkbox"/> Standard <input type="checkbox"/> Retiree/Spouse <input type="checkbox"/> Savings (not Medicare-eligible) <input type="checkbox"/> Retiree/Child(ren) <input type="checkbox"/> TRICARE Supp (not Medicare-eligible) <input type="checkbox"/> Family	<b>18. STATE DENTAL PLAN</b> <input type="checkbox"/> Refuse <input type="checkbox"/> Retiree <input type="checkbox"/> Retiree/Spouse <input type="checkbox"/> Retiree/Child(ren) <input type="checkbox"/> Family	<b>19. DENTAL PLUS</b> (Select One) <input type="checkbox"/> Refuse <input type="checkbox"/> Yes You must be enrolled in the State Dental Plan to select Dental Plus.	<b>20. VISION CARE</b> (Select One) <input type="checkbox"/> Refuse <input type="checkbox"/> Retiree <input type="checkbox"/> Retiree/Spouse <input type="checkbox"/> Retiree/Child(ren) <input type="checkbox"/> Family
-----------------	--	--	---	---

**21. List yourself and any other persons to be covered who are eligible for Part A and/or Part B of Medicare. Please include copy of Medicare card.**

MEDICARE	Name	Medicare #	Eligible Due To	Effective Date	
				Part A MM/DD/YYYY	Part B MM/DD/YYYY
			<input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> Renal Disease		
			<input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> Renal Disease		
			<input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> Renal Disease		

**22. Always list spouse. List all 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.**

DEPENDENTS	Add (A) or Delete (D)	Dependent SSN#	Last Name	First Name	Sex M/F	Relationship	Date of Birth MM/DD/YYYY	Indicate Special Status
								<input type="checkbox"/> Incapacitated
								<input type="checkbox"/> Incapacitated
								<input type="checkbox"/> Incapacitated

<b>23. CERTIFICATION:</b> I have read this NOE and made authorizations herein and selected the coverages 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. <b>AUTHORIZATION:</b> 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. <u>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.</u>
Enrollee Signature _____	Date _____

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

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

**ELIGIBILITY:** For new retirees only. Select a retiree type to indicate your eligibility as a retiree. Enter the length of service, and complete and attach the Employment Verification Record form. If your most recent hire date is on or after July 1, 1984, and you have fewer than 10 years service credit, check the "5-10 year retiree" block. Check the "age 55/25 years retiree" block if you are retiring under the "age 55 with 25 years service credit" provision, and enter the date you will reach age 60 or 28 years, whichever occurs first. Check the TERI retiree block if you are retiring under the South Carolina Retirement System Teacher and Employee Retention Incentive program (TERI) provision, and indicate the ending date. Employer verification of eligibility is required only for retirees of participating cities, counties, disabilities and special needs boards, water and sewer districts, alcohol and drug abuse agencies, special hospital districts, special purpose districts, recreation districts and municipalities.

**ACTION:** If you are enrolling as a retiree for the first time, check "New Subscriber" and enter your date of retirement. If you are already enrolled as a retiree and are making a change, check "Change" and indicate the type of change and date of the event causing the change. If you were previously enrolled as a retiree and are now returning to retiree coverage, check "Previously enrolled as a Retiree - returning to Retiree status." If you wish to end your retiree coverage, check "Termination."

**ENROLLEE INFO: Blocks 1-16** must be completed for all transactions including terminations. **In block 16**, enter the county code (listed below) of your mailing address.

### 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 IN THIS SECTION ARE NOT ALLOWED:

**Block 17. HEALTH:** Select one health plan and one level of coverage or check "Refuse." If you refuse health coverage or fail to enroll yourself and all eligible dependents within 31 days of eligibility, you can enroll yourself and/or your dependent(s) only during an open enrollment period or within 31 days of a special eligibility situation. Changes from one health plan to another are allowed only during designated enrollment periods (exceptions: changing plans due to Medicare eligibility). The Savings Plan is available only to non-Medicare-eligible enrollees and dependents.

**Block 18. DENTAL:** Select level of dental coverage or "Refuse." If you refuse dental coverage or fail to enroll yourself and all eligible dependents within 31 days of eligibility, you can enroll yourself and/or your dependents only during an open enrollment period in an odd-numbered year or within 31 days of a special eligibility situation.

**Block 19. DENTAL PLUS:** Select "Yes" to enroll or "Refuse". 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 20. VISION CARE:** Select a level of vision care coverage to enroll or "Refuse." If you refuse coverage or fail to enroll yourself and all eligible dependents within 31 days of eligibility, you can enroll yourself and/or your dependents during the next enrollment period (October) or within 31 days of a special eligibility situation.

**MEDICARE:** In **block 21**, list yourself and any other persons to be covered who are eligible for Part A and/or Part B of Medicare.

**Block 22. DEPENDENTS:** Legal documentation is required for all dependents. List your spouse and whether he is an employee or retiree of a PEBA Insurance Benefits-covered employer. A spouse can only be covered as a dependent if his is not an employee or retiree of an employer that participates in the State of South Carolina Insurance Benefits Program. List all dependents to be covered. If they are not listed, they will not be covered.

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:** Read **block 23** carefully, sign and date form. Send the original form and any required documentation to PEBA Insurance Benefits, P.O. Box 11661, Columbia, SC 29211. Keep a copy for your records.

## Employment verification record

1. BIN or last four digits of SSN		2. Last name		3. First name	
4. Telephone number		5. Date of birth		6. Type of retirement <input type="checkbox"/> Service <input type="checkbox"/> Disability (attach Disability Approval letter)	
7. Did you participate in TERI? <input type="checkbox"/> No <input type="checkbox"/> Yes – TERI end date: _____			8. Actual date of retirement: _____		
9. Name of current employer		Dates of employment (example Jan 2009 to Mar 2001)		Status <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	Service credit (years and months) ____ Yrs ____ Mos
10. List previous employment with employers participating in one of the retirement systems administered by PEBA and/or with local subdivisions participating in PEBA's insurance benefits.					
Name of employer		Dates of employment (ex. Jan 2009 to Mar 2001)		Status <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	Service credit (years and months) ____ Yrs ____ Mos
				<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	____ Yrs ____ Mos
				<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	____ Yrs ____ Mos
				<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	____ Yrs ____ Mos
				<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	____ Yrs ____ Mos
				<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	____ Yrs ____ Mos
				<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	____ Yrs ____ Mos
				<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	____ Yrs ____ Mos
11. Do you have any additional service time established with one of the retirement systems administered by the PEBA? (ex. purchased time, military, out-of-state, etc.)				<input type="checkbox"/> Yes (list time) <input type="checkbox"/> No	____ Yrs ____ Mos
12. Total years of service credit					____ Yrs ____ Mos

If you are a member of one of the defined benefit plans administered by PEBA, we will review your service records to determine eligibility for retiree insurance. Please check all that apply:

- |  |  |
|--|--|
| <input type="checkbox"/> South Carolina Retirement System  | <input type="checkbox"/> Judges and Solicitors Retirement System |
| <input type="checkbox"/> Police Officers Retirement System | <input type="checkbox"/> General Assembly Retirement System      |

This section should only be completed if you are a State Optional Retirement Program (State ORP) participant or the employee of an employer that does not participate in one of the retirement systems administered by PEBA. Your benefits administrator must verify your employment history **with his employer only** and sign the verification record. By signing below, you certify the information provided is complete and accurate.

- State Optional Retirement Program     Employer does not participate in a PEBA administered retirement plan.

Service credit: \_\_\_\_\_ years \_\_\_\_\_ months

Benefits administrator's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Enrollee's signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **INSTRUCTIONS**

The Employment Verification Record is used to determine eligibility for retiree insurance.

If you are retiring within 90 days, please submit the Retiree Notice of Election (RNOE) to PEBA Insurance Benefits with the Employment Verification Record. If you are eligible for retiree coverage, PEBA Insurance Benefits will need both of these forms to process your enrollment in retiree coverage. These forms must be sent no later than 31 days after your retirement date.

If you are not ready to retire, but are inquiring about your eligibility in the future, you may submit the Employment Verification Record to PEBA Insurance Benefits with a letter indicating your anticipated retirement date. Please note: **PEBA Insurance Benefits will verify eligibility for retiree insurance no more than 6 months prior to retirement.**

Mail forms to: PEBA Insurance Benefits  
P. O. Box 11661  
Columbia, SC 29211

### Block 6 – Type of Retirement

Service Retirement indicates eligibility is based solely on the years of service credited through one of the retirement systems administered by the S.C. Public Employee Benefit Authority. Disability Retirement indicates eligibility based on qualification as a disabled retiree. Please attach a copy of your disability approval letter from one of the retirement systems administered by the S.C. Public Employee Benefit Authority.

### Block 8 – Actual Date of Retirement

List the date of retirement established with one of the retirement systems administered by the S.C. Public Employee Benefit Authority. If you continued working in a full-time benefits eligible position after your retirement date, list the date you left active employment\* or your TERI end date whichever is later.

\*For retirement purposes, when a member begins TERI, he is retired.

### Block 9 – Name of Current Employer

List the name of your current state or local subdivision employer. If you are not currently employed by an employer participating in PEBA Insurance Benefits, do not complete this section. Proceed to Block 10.

### Block 10 – Previous Employers

List all previous employment with employers participating in one of the retirement systems administered by the S.C. Public Employee Benefit Authority and/or with a Local Subdivision participating in PEBA Insurance Benefits. Please include service time established in the appropriate sections.

### Block 11 – Additional Service Time

If you purchased service or reestablished service, please list the total number of years established.

Block 12 - Total Years of Service Credit – This number is calculated by adding the total years of service from blocks 9, 10 and 11. If you are submitting a Retiree Notice of Election (RNOE) to enroll in retiree coverage, this information is required in the eligibility section of the form.

***Please note: PEBA Insurance Benefits cannot process your enrollment in retiree coverage until your employer terminates your active insurance coverage. Please notify your employer of your retirement date as soon as possible to ensure timely processing of your retiree enrollment.***

## Certification regarding tobacco use

Check the appropriate box, sign and return to S.C. PEBA, 202 Arbor Lake Drive, Columbia, SC 29223.

Subscriber name: \_\_\_\_\_ Subscriber BIN/SSN: \_\_\_\_\_

### Non-tobacco user premium

- I certify that I am eligible for the Non-Tobacco-User Premium by checking this box and returning this form to PEBA. By checking this box, I certify truth and understanding of the following:
  - I certify that all persons covered on my health insurance coverage through PEBA (including myself and any dependents) are not currently using, and have not used, any tobacco products in any form (cigarettes, cigars, pipe, oral tobacco products, etc.) within the last six months.
  - I certify that if this information changes at any time in the future, while I have health insurance coverage through PEBA, I will notify PEBA of such change within 30 days through completion and resubmission of this form.
  - I certify that this information is true and correct to the best of my knowledge.
  - I understand that if it is determined that I (or any of my covered dependents) have used tobacco products within the last six months or if I (or any of my covered dependents) start using tobacco products subsequent to the date of this certification without notifying PEBA, I will be subject to penalties including, but not limited to, payment of premium difference since last certification plus a 10 percent penalty and elimination of tobacco user's out-of-pocket maximum for current year and subsequent year.
  - I understand that this change in premiums will be prospective (apply only to premiums I pay in the future). I will not be refunded any part of the Tobacco-User Premium I have already paid.
- I certify that I am eligible for the Non-Tobacco-User Premium by checking this box and returning this form to PEBA Insurance Benefits. By checking this box, I certify truth and understanding of the following:
  - I certify that all covered individuals who use tobacco have completed the Quit for Life® smoking cessation program.
  - I certify that this information is true and correct to the best of my knowledge.
  - I understand that this change in premiums will be prospective (apply only to premiums I pay in the future). I will not be refunded any part of the Tobacco-User Premium I have already paid.

### Tobacco user premium

- I acknowledge that I will pay the Tobacco-User Premium by checking this box. I declare that one or more persons covered on my health insurance coverage through PEBA uses tobacco products in some form or that I choose not to disclose my status as it relates to tobacco use. I understand that by not making an election I am choosing to pay the Tobacco-User Premium. Please do not send me this certification again unless upon request.

Subscriber signature: \_\_\_\_\_ Date: \_\_\_\_\_

Benefits administrator signature: \_\_\_\_\_ Date: \_\_\_\_\_

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 contact of employment.

# Continuation vs. Converting Group Life Coverage



SC PEBA	Retiree Continuation	Conversion
<b>Eligible coverage</b>	<ul style="list-style-type: none"> <li>Employee Optional Term Life coverage can be continued.</li> </ul>	<ul style="list-style-type: none"> <li>Employee Basic and Optional Term Life coverages can be converted.</li> <li>Dependent Term Life coverage can be converted.</li> <li>Coverage lost due to an age reduction can be converted.</li> </ul>
<b>Type of insurance following election</b>	Group Term Life	Individual Life policy
<b>Eligibility timing (enrollment period)</b>	Must be elected within 31 days of the end of event below.	Must be elected within 31 days of the end of event below.
<b>Events allowing continuation/conversion</b>	Coverage is lost due to: <ul style="list-style-type: none"> <li>Approved retirement</li> <li>Approved disability retirement</li> </ul>	Coverage is lost due to: <ul style="list-style-type: none"> <li>Loss of eligibility for active coverage</li> <li>Disability</li> <li>Age reduction at 70</li> </ul>
<b>Not allowed for</b>	Coverage is lost due to: <ul style="list-style-type: none"> <li>Termination of group policy</li> <li>Nonpayment of premium</li> </ul>	Coverage is lost due to: <ul style="list-style-type: none"> <li>Nonpayment of premium</li> </ul>
<b>Guaranteed issue</b>	All guaranteed issue	All guaranteed issue
<b>Maximum age to elect</b>	Age 74	No maximum age
<b>Minimum amount allowed</b>	\$10,000	No minimum
<b>Maximum amount allowed</b>	<ul style="list-style-type: none"> <li>100% of your Optional Term Life coverage you had as an active employee.</li> <li>Coverage amounts limited to \$10,000 increments.</li> </ul>	Previous amount in force unless conversion is due to policy or class termination. If conversion is due to policy or class termination, there may be a limitation, depending on applicable state law.
<b>Age reductions</b>	Coverage reduces to 65% at age 70.	No age reductions
<b>Termination age</b>	Age 75	No termination age
<b>Premium billing</b>	You will be billed after completed election form and coverage verification notice are submitted.	You must send first premium payment with conversion application and coverage verification notice.

Premium rates for continued retiree Group Term Life insurance are the same rate paid as an active employee. Retiree life insurance does not include Accidental Death and Dismemberment (AD&D). The following are examples of the monthly premium rates based on an approximate age and a coverage amount of \$10,000. All rates are subject to change.

Sample Continuation vs. Conversion		
Age	Term Continuation	Conversion*
45	\$1.08	\$21.52
55	\$2.96	\$33.23
60	\$5.48	\$55.78
65	\$11.60	\$78.57

*\*The conversion application period is time-sensitive. If you are interested in converting your group coverage, you must call 866-486-5298 to obtain a conversion brochure. You must complete your conversion application and mail it along with your coverage verification notice and your first premium payment within 31 days of loss of coverage.*



## PEBA Coverage Verification Notice of Group Life Insurance

**Instructions for PEBA policyholder/record keeper:** Complete this Notice and provide a copy to the retiree when group coverage terminates or reduces. If coverage has been assigned, provide notice to assignee of coverage termination. If an accelerated benefits claim was paid on this life insurance coverage, indicate the remaining amount of coverage following claim payment.

**Instructions for eligible Retiree:** Upon retirement or reduction of group insurance, you may either continue or convert your life insurance coverage. Both options are available without medical examination (guarantee issue) if you enroll within the application period.

**To continue coverage:** Complete the “Retiree Life Continuation” form and return it within 31 days of your retirement.

**To convert coverage:** You must call 866-486-5298 to obtain a conversion brochure. The conversion application period is time-sensitive. You must complete your conversion application and send first premium due within 31 days of loss of coverage.

### Return a copy of this Coverage Verification Notice with your Election form

Eligible Person / Retiree			
Date of this notice	Date leaving employer’s active Group Life plan or date coverage reduces		
Name of insured	Date of birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Address (street, city, state, zip)	BIN (this number is on your medical card)		

Coverage verification			
Reason for termination	<input type="checkbox"/> Retirement	<input type="checkbox"/> Termination of employment	<input type="checkbox"/> Coverage reduction due to age
Coverage type	Coverage amount	Options	
Basic Term Life	\$	Conversion only – Call 866-486-5298	
Optional Term Life	\$	Conversion or continuation	
Dependent Spouse Term Life	\$	Conversion only – Call 866-486-5298	
Dependent Child Term Life	\$	Conversion only – Call 866-486-5298	
Date to which group premiums were paid for this individual			

**I certify that the information given by this employee concerning employment and group life insurance with us is correct according to our records.**

Group policyholder <b>South Carolina PEBA</b>	BA address	BA phone number
Print name of authorized benefits administrator or PEBA staff	Email	
Signature of benefits administrator or PEBA staff <b>X</b>	Date	

**Mail or fax a copy of this notice along with your completed election form to:  
 Securian • Group Customer Service • 400 Robert Street N • St Paul, MN 55101  
 Fax 651-665-4827**

# Election - Retiree Life Continuation

**Securian Financial Group, Inc.**  
 Minnesota Life Insurance Company  
 Securian Life Insurance Company, a New York authorized insurer  
 400 Robert Street North • St. Paul, MN 55101-2098

Group Customer Service  
 Fax 651-665-4827



Employer name <b>South Carolina PEBA</b>	Policy number <b>34407</b>
---	-------------------------------

**Retiree Information**

Name	Date of birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Address (street, city, state, zip)		Cell or daytime phone number
Email address	Employment location	Date leaving employer's active plan
BIN (this number is on your medical card)		

Optional term life amount to be continued (*Send your PEBA coverage verification from your employer*)  
 \$

**PRIMARY BENEFICIARY(IES) - The person or persons named will receive the proceeds.**

Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security number	Relationship	Share % (must total 100%)

**CONTINGENT BENEFICIARY(IES) – If the primary beneficiary (ies) is no longer living, the proceeds are paid to this person(s). The same person cannot be named as a primary and a contingent beneficiary.**

Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security number	Relationship	Share % (must total 100%)

Please indicate how you would like to be billed:    Quarterly    Semi-Annually    Annually

**Do not send a premium payment in with this completed form.** You will be billed for the first premium payment after receiving your completed election form. Future premiums may be billed quarterly, semi-annually or annually. You will have the option of a monthly EFT draft after your initial payment is received and processed. A \$2.00 fee is charged per premium payment for administrative fees, unless billed annually.

**To be eligible you must apply within 31 days of the date your previous coverage terminated.**

Applicant signature <b>X</b>	Date signed
---------------------------------	-------------

**Please mail or fax your completed form along with your PEBA coverage verification and BIN to:  
 Securian • Group Customer Service • 400 Robert Street N • St Paul, MN 55101  
 Fax 651-665-4827**