PART-TIME NOTICE OF ELECTION (NOE)

SOUTH CAROLINA PUBLIC EMPLOYEE BENEFIT AUTHORITY

P

See Instructions - if completing by hand use black ink

You must also complete a *Certification Regarding Tobacco Use* 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.

Clear Form

ACTION

Select One	Type of Change	BA Use Only
☐ New Hire/Newly Eligible	☐ Enrollment	Effective Date: _____ ☐ Permanent P/T EE *(20 hrs.)*
☐ Transfer	Other (*specify*) _____	Group ID #: _____ Pay periods per year: _____
☐ Change	Date of Change Event _____	Group Name: _____

ENROLLEE INFO

1. Social Security number or 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. Email Address
☐ M ☐ F	☐ Single ☐ Divorced ☐ Widowed ☐ Married ☐ Separated			

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

It is your responsibility to select the appropriate 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

COVERAGE

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

PLAN	COVERAGE LEVEL
☐ Refuse	☐ Employee
☐ Standard	☐ Employee/Spouse
☐ Savings	☐ Employee/Child(ren)
☐ TRICARE Supplement	☐ Family

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

PLAN	COVERAGE LEVEL
☐ Refuse	☐ Employee
☐ Dental Plus	☐ Employee/Spouse
☐ Basic Dental	☐ Employee/Child(ren)
	☐ Family

23. VISION CARE *(select one)*

☐ Refuse
☐ Employee
☐ Employee/Spouse
☐ Employee/Child(ren)
☐ Family

MONEYPLUS ELECTIONS

24. MONEYPLUS ELECTIONS **MoneyPlus Pretax Premiums** ☐ Refuse ☐ Enroll

If you enroll in a Health Savings Account (Section C), you cannot enroll in a Medical Spending Account (Section A), but may enroll in a Limited-use Medical Spending Account (Section D). There is a monthly fee of $2.14 for Medical Spending, Dependent Care, and Limited-use Medical Spending accounts. There is a monthly fee of $0.50 for Health Savings Accounts.

A. MEDICAL SPENDING ACCOUNT

☐ New Enrollment ☐ Reenrollment ☐ Refuse

Receive reimbursement for eligible medical expenses incurred by you, your family members, or both. The maximum allowable contribution is $3,300 annually.

Plan year total amount: $ _____

B. DEPENDENT CARE SPENDING ACCOUNT (for child/adult daycare)

☐ New Enrollment ☐ Reenrollment ☐ Refuse

Tax filing status, please check one:

☐ Married, filing separately (Maximum - $2,500*) _____ Daycare costs increase/decrease
☐ Single, head of household (Maximum - $5,000*) _____ Dependent child turns 13
☐ Married, filing jointly (Maximum - $5,000*)

Plan year total amount: $ _____ **Contribution limit for highly compensated employees is $1,600.*

C. HEALTH SAVINGS ACCOUNT

☐ New Enrollment ☐ Contribution Amount Change ☐ Refuse

Select which type of State Health Plan Savings Plan coverage you have:

☐ Individual (Maximum - $4,300)
☐ Family (Maximum - $8,550)
☐ Over 55 Catch-up (additional $1,000)

Plan year total amount: $ _____

D. LIMITED-USE MEDICAL SPENDING ACCOUNT

☐ New Enrollment ☐ Reenrollment ☐ Refuse

Receive reimbursement for eligible dental and vision expenses incurred by you, your family members, or both. The maximum allowable contribution is $3,300 annually.

Plan year total amount: $ _____

Qualified Change Events (Check and date all that apply) for A & B:

_____ Marriage	_____ Spouse/dependent passed away	_____ Spouse ends unpaid leave	_____ Other
_____ Newborn	_____ Employee begins unpaid leave	_____ Spouse begins unpaid leave	
_____ Adoption	_____ Employee ends unpaid leave	_____ Job change from part-time to full-time	
_____ Divorce	_____ Ineligible dependent child	_____ Job change from full-time to part-time	

EMPLOYEE INITIALS _____ **DATE** _____

Social Security number: _____ **BIN:** _____ **Last Name:** _____ **First Name:** _____

MEDICARE

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

Name	Medicare #	Eligible due to	Effective Date	
			Part A (MM/DD/YYYY)	Part B (MM/DD/YYYY)
		☐ 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 a child age 19-24 to be eligible for Dependent Life-Child coverage, your child must be eligible according to the requirements on the instructions page for this NOE.

Add (A) or Delete (D)	Dependent SSN	Last Name	First Name	Sex	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
	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 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. 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 required documentation is attached to process NOE form.

Benefits Administrator Signature _____ Phone _____ Date _____

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

IF COMPLETING BY HAND, USE BLACK INK

You must also complete a Certification Regarding Tobacco Use 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.

ACTION: Indicate type of action. MoneyPlus: Premiums for health, dental, and vision are deducted on a pretax basis unless refused. MoneyPlus changes must be made during enrollment or within 31 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	07 Beaufort	13 Chesterfield	19 Edgefield	25 Hampton	31 Lee	37 Oconee	43 Sumter
02 Aiken	08 Berkeley	14 Clarendon	20 Fairfield	26 Horry	32 Lexington	38 Orangeburg	44 Union
03 Allendale	09 Calhoun	15 Colleton	21 Florence	27 Jasper	33 McCormick	39 Pickens	45 Williamsburg
04 Anderson	10 Charleston	16 Darlington	22 Georgetown	28 Kershaw	34 Marion	40 Richland	46 York
05 Bamberg	11 Cherokee	17 Dillon	23 Greenville	29 Lancaster	35 Marlboro	41 Saluda	99 Out of S.C
06 Barnwell	12 Chester	18 Dorchester	24 Greenwood	30 Laurens	36 Newberry	42 Spartanburg	

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 31 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 apply for coverage for yourself and your dependent(s) only during an open enrollment period during an odd-numbered year or within 31 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. VISION CARE: Before making a selection, refer to the plan description provided by your employer.

Block 24. MONEYPLUS ELECTIONS: To enroll in a **Medical Spending Account**, complete **Section A**. To enroll in a **Dependent Care Spending Account**, complete **Section B**. Complete **Section C** to enroll in or to change a **Health Savings Account**. (Additional forms will be required to establish your HSA.) If you would also like to enroll in a **Limited-used Medical Spending Account** for eligible dental and vision expenses, complete **Section D**.

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. DEPENDENTS: 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 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 employer covered by PEBA insurance, 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 31 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.

PEBA Insurance Benefits, Operations, P.O. Box 11661, Columbia, SC 29211.