RETIREE NOTICE OF ELECTION - OPEN ENROLLMENT

SOUTH CAROLINA PUBLIC EMPLOYEE BENEFIT AUTHORITY

R-OE

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

ELIGIBILITY

Verification of eligibility *(required of retirees from employers other than state agencies and school districts)*

Benefits Administrator Signature _____ Employer ID:

ACTION

Select One

☐ Open Enrollment Effective Date: 1/1/2027

PEBA Use Only

Employer ID:

Effective Date: _____

Group ID:

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. Email Address
☐ M ☐ F	☐ Single ☐ Divorced ☐ Widowed ☐ Married ☐ Separated		

11. Mailing Address	12. Apt.	13. City	14. State	15. Zip Code	16. County Code

COVERAGE

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

PLAN	COVERAGE LEVEL
☐ Refuse ☐ Medicare Supplemental	☐ Retiree
☐ Standard	☐ Retiree/Spouse
☐ Savings (not Medicare-eligible)	☐ Retiree/Child(ren)
☐ TRICARE Supplement (not Medicare-eligible)	☐ Family

18. DENTAL ***- NO CHANGES IN ODD NUMBERED YEARS***

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

19. VISION CARE *(select one)*

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

MEDICARE

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

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

21. Always list spouse, if applicable. List eligible children to be covered. If they are not listed, they will not be covered. For a child ages 19-24 to be eligible for Dependent Life-Child coverage, your child must be eligible according to the requirements on the instructions page of 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

22. 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 and agree that all selected plans will not become effective unless and until this NOE is submitted and the first payment is made. I understand my COBRA continuation coverage rights and responsibilities, as explained in the election notice and attachments provided to me. I also 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 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.

Enrollee/Guardian Signature _____ Date _____

INSTRUCTIONS FOR COMPLETING THE RETIREE NOTICE OF ELECTION - OE

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.

ELIGIBILITY: Employer verification 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: This form is for Open Enrollment changes only. Only mark the changes you want to make. To cancel coverage, mark refuse and not a coverage level. Dental changes are allowed during odd numbered years only.

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

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 IN THIS SECTION ARE NOT ALLOWED.

Block 17. HEALTH: Select one health plan and one level of coverage or select Refuse. Changes from one health plan to another are allowed during designated enrollment periods only (exceptions: changing plans due to Medicare eligibility). The Savings Plan is available only to non-Medicare-eligible enrollees and dependents. For dependents to be covered, you must list them in Block 21, and select the appropriate coverage level.

Block 18. DENTAL: Changes to existing dental coverage can be made during open enrollment in odd-numbered years only. Your next opportunity to make a change to your dental coverage during open enrollment will be October 2027 or within 31 days of a special eligibility situation.

Block 19. VISION CARE: Select a level of vision care coverage to enroll or Refuse. For dependents to be covered, you must list them in Block 21, and select the appropriate coverage level.

Block 20. MEDICARE: List yourself and any other persons to be covered who are eligible for Part A and/or Part B of Medicare. Include a copy of your and/or your dependent's Medicare card.

Block 21. 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 they are not an employee or retiree of an employer that participates in the state of insurance benefits program. If your spouse is an employee or retiree of an employer covered by PEBA insurance, select Yes. A child younger than age 26 is eligible for health, dental and vision coverage. Misstatements on the NOE might result in termination of the dependent's coverage and recoupment of benefits paid on behalf of the ineligible dependent.

CERTIFICATION AND AUTHORIZATION: Read this block 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.