

STATE EMPLOYEE HEALTH PLAN (SEHP) 2013 ENROLLMENT FORM INSTRUCTIONS

Please complete the form in its entirety. Please print clearly and legibly. Make sure the employee and HR Officer both sign and date the form.

1. Effective date of coverage - except for birth of a child, adoption or placement, this will always be the 1st day of the month (required)
2. Employee ID Number (required)
3. Agency **or** Non State Employer Group (NSEGroup)Number (required)
4. Full Name of Employee (required)
5. Employee's current mailing address
6. Valid Contact Employee Email Address (required)
7. Employee's Phone number for telephone contact (required)
8. Employee's Social Security Number or ITIN (required)
9. Employee's Gender (required)
10. Employee's Date of birth (required)
11. Date of qualifying event (required)
12. Check the box to indicate the type of action. When "Other" is checked, use the narrative space to explain additional circumstances (required)
13. Date the employee was employed in a benefits eligible position [date of hire] (required)
14. Date the employee was employed in a **non**-benefits eligible position [date of hire] (required)
15. Indicate the Salary Tier for the employee (required)
16. Darken the box to describe the employee's choice as to whether to pay premiums before or after tax (required)
17. Indicate whether the employee is currently enrolled as a dependent in the SEHP (required)
18. Member elects one medical insurance provider for the plan year—unless they are waiving coverage
19. Indicate the employee's Medical and prescription drug coverage level choice. Codes are on the back of the Enrollment Form. If employee is electing to waive, select "Waive Coverage"(required)
20. Dental coverage level - employee dental coverage is required. If dependent medical coverage is selected, the employee may add dependent dental coverage. The dental coverage level will match the Medical coverage level and will have the same dependents enrolled in dental that are enrolled in Medical
21. Employee elects Vision coverage plan. Employee may elect to waive vision coverage.
22. Vision coverage level – employee may select any level of vision coverage. If medical and vision coverage for children is selected, the same children that are covered under the medical must be covered under the vision.
23. Enter the Relationship Code (found on the back of the Change Form) of the dependent(s) (required if action affects dependents)
24. Enter the full name of the dependent(s) (required if action affects dependent)
25. Enter the Social Security Number, ITIN or HICN of the dependent(s) (required if action affects dependent)
26. Enter the gender of the dependent(s) (required if action affects dependent)
27. Enter the date of birth of the dependent(s) (required if action affects dependent)
28. Darken the correct box to indicate whether the dependent's address is the same as the Member or not. If it is not, enter the dependent's address (if the action affects the dependent)

- 29.** Enter the name of the Medicare eligible member (if applicable)
- 30.** Enter the date of eligibility for Medicare Part A (if applicable)
- 31.** Enter the date of eligibility for Medicare Part B (if applicable)
- 32.** Enter the member / dependent's Medicare Claim Number, from the Medicare card (if applicable)
- 33.** Employee's signature and the date the form was signed
- 34.** Printed name, signature, signature date, and phone number of the employee's Personnel Officer