PEEHIP New Enroll/Status Chg
(07/15)
6U

Check One:
☐ Active Member
☐ Retired Member

NEW ENROLLMENT AND STATUS CHANGE

Public Education Employees' Health Insurance Plan
P. O. Box 302150 + Montgomery, Alabama 36130-2150
334.517.7000 or 877-517-0020; Fax: 334.517.7001 or 877.517.0021
You may submit information online at **https://mso.rsa-al.gov**

PEEHIP Subscriber Information

Name must be entered as shown on your Social Security card.

Social Security # or PID	First Name	Middle Initial	Last Name	Date of Birth	Sex
				____/____/____	☐ M ☐ F

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed — Date Married: ____/____/____

Is your spouse employed? ☐ Yes ☐ No — Does your spouse have other health insurance coverage? ☐ Yes ☐ No

Mailing Address	City	State	ZIP Code

Is this a change of address?	Home Phone	Cell Phone	Work Phone
☐ Yes ☐ No	____-____-____	____-____-____	____-____-____

Employer/School System	Date of Employment	Email Address
	____/____/____	

Have you or your spouse used tobacco products within the last 12 months?* — Member: ☐ Yes ☐ No — Spouse: ☐ Yes ☐ No
This information is required for enrollment.

PEEHIP Coverage Information

(You will be billed for prorate premiums or premiums that are not deducted from your payroll or retirement check.)

Section A. New Enrollment

Basic Hospital/Medical
(PEEHIP plans are administered by Blue Cross and Blue Shield of AL)

Coverage Type: (*select only one of the three plans*)
☐ PEEHIP Hospital/Medical
☐ VIVA Health Plan (HMO) (Primary Care Physician _____)
☐ PEEHIP Hospital/Medical Supplemental**(*Secondary Medical*)
***Complete Primary Insurance Information in Section D if choosing this plan. This plan is not a Medicare supplement & differs from Optional Plans.*

☐ Single or ☐ Family *(complete Section C)*

Requested Effective Date ____/____/____ ***(required)***

Optional Coverage Plans
(administered by Southland National)

Note: *Optional plans must be all Single or all Family*
Coverage Type(s):
☐ Cancer ☐ Dental ☐ Indemnity ☐ Vision

☐ Single or ☐ Family *(complete Section C)*

These plans must be retained for one year until the following October 1. PEEHIP will not automatically cancel any coverage(s).

Requested Effective Date ____/____/____ ***(required)***

Section B. PEEHIP Coverage Information (Only check boxes requiring a change to **existing** coverage.)

Coverage Type:	PEEHIP Hosp/Med	**PEEHIP Supplemental	VIVA HMO	Cancer	Dental	Indemnity	Vision
Change from Single to **Family** Coverage	☐	☐	☐	☐	☐	☐	☐
Add dependent(s) listed in Section C to Family Coverage	☐	☐	☐	☐	☐	☐	☐
Cancel Coverage	☐	☐	☐	☐	☐	☐	☐
Change from Family to **Single** Coverage	☐	☐	☐	☐	☐	☐	☐
Cancel dependent(s) listed in Section C from Family Coverage	☐	☐	☐	☐	☐	☐	☐

Requested Effective Date ____/____/____ ***(required) QLE changes must be submitted within 45 days of the QLE.***

Reason for Status Change(s) *(check all that apply)*

Changes cannot be processed without the appropriate documentation as explained in the Member Handbook for starred (*) items.

Date change occurred ***(Required)*** ____/____/____

☐ Open Enrollment – **Change effective October 1st**
☐ Adoption of a child* *(need adoption papers)*
☐ Birth of a child* *(need birth certificate)*
☐ Death of spouse/dependent* *(need death certificate)*
☐ Qualifying loss of coverage* *(need proof of loss of coverage)*
☐ Divorce/Annulment/Legal Separation* *(need divorce decree)*
☐ FMLA/LOA
☐ Legal custody of a child* *(need legal custody papers)*
☐ Marriage* *(need marriage certificate & add'l proof of marriage)*
☐ Marriage of dependent child* *(need marriage certificate)*
☐ Termination of spouse/dependent employment*
☐ Commencement of spouse/dependent employment*
☐ Medicare/Medicaid entitlement* *(need copy of card)*

Note: Active members must have an IRS qualifying life event (QLE) to cancel their Hospital Medical or change their coverage outside of Open Enrollment because their premiums are pre-taxed. ***QLE changes must be submitted within 45 days of the QLE.***