

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

**PERMANENT PART-TIME TEACHER NOTICE OF ELECTION (NOE)
SOUTH CAROLINA BUDGET AND CONTROL BOARD
EMPLOYEE INSURANCE PROGRAM (EIP)**

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See Instructions - If Completing
By Hand Use Black Ink

ACTION	Select One:	<input type="checkbox"/> Address Change _____ <input type="checkbox"/> Other (Specify) _____ Date of Change Event _____ SSN Change - Incorrect # _____ (Attach Copy of Social Security Card) Name Change - Prior Name _____	BA Use Only	MoneyPlus\$ Pretax Premiums
	<input type="checkbox"/> New Hire <input type="checkbox"/> Transfer <input type="checkbox"/> Change	Effective Date: _____ Group ID#: _____ Group Name: _____	<input type="checkbox"/> Refuse <input type="checkbox"/> Yes	

1. Social Security Number (SSN)	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 <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	9. Home Phone # ()	10. Work Phone # ()	11. E-mail Address	
12. Mailing Address		13. Apt.	14. City	15. State	16. Zip Code
			17. County Code	18. Annual Salary	19. Date of Hire MM/DD/YYYY

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

20. CATEGORY (Number of hrs. worked) I. 15-19 hours II. 20-24 hours III. 25-29 hours

21. HEALTH PLAN (Basic Life/Basic LTD not provided with health coverage) (Refuse or select one plan and one level of coverage) PLAN <input type="checkbox"/> Refuse <input type="checkbox"/> HMO _____ <input type="checkbox"/> Standard <input type="checkbox"/> Savings (Not Medicare-eligible) Name of HMO _____ COVERAGE LEVEL (Select One) <input type="checkbox"/> Employee <input type="checkbox"/> Family <input type="checkbox"/> Employee/Child(ren) <input type="checkbox"/> Employee/Spouse	22. STATE DENTAL PLAN (Select One) <input type="checkbox"/> Refuse <input type="checkbox"/> Family <input type="checkbox"/> Employee <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child(ren)	23. DENTAL PLUS (Select One) <input type="checkbox"/> Refuse <input type="checkbox"/> Yes	24. VISION CARE (Select One) <input type="checkbox"/> Refuse <input type="checkbox"/> Family <input type="checkbox"/> Employee <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child(ren)
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25. List yourself and any other persons to be covered who are eligible for Part A and/or Part B of 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		

26. Do you or any of your dependents have other health coverage? YES NO Does this coverage include prescription drug benefits? YES NO
 If you and/or your dependents have had other coverage with another carrier within 62 days of this request, please attach a copy of your certificate of health coverage. This will ensure proper credit for any pre-existing condition exclusions.

Dependent Name	Insurance Company	Policy Holder Date of Birth	Effective Date of Policy	Termination Date (If Applicable)

27. Always list spouse. List eligible children to be covered. If they are not listed, they will not be covered.

Add (A) or Delete (D)	Dependent SSN#	Last Name	First Name	Sex M/F	Relationship	Date of Birth MM/DD/YYYY	Indicate Special Status
							Is spouse employed with, or retired from, an EIP-covered employer? <input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Full-time student <input type="checkbox"/> Incapacitated
							<input type="checkbox"/> Full-time student <input type="checkbox"/> Incapacitated
							<input type="checkbox"/> Full-time student <input type="checkbox"/> Incapacitated

<p>28. 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 that unless otherwise provided in the Plan, I may cancel coverage for me or my dependent(s) only during an open enrollment period (every two years). 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 (every two years) 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.</p> <p>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</p>	<p>healthcare provider, prescription drug dispenser and claims administrator to release any information necessary to evaluate, administer and process claims for any benefits.</p> <p><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></p> <p>Employee Signature _____ Date _____</p>
<p>29. 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.</p> <p>Benefits Administrator Signature _____ Date _____</p>	

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

IF COMPLETING BY HAND, USE BLACK INK

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

ACTION: Indicate type of action. MoneyPlu\$: Premiums for health, dental, vision and Optional Life Insurance are deducted on a pretax basis unless refused. There is an administrative fee for the pretax deductions. MoneyPlu\$ 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	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 (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 (every two years) 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 27**, and the appropriate level of coverage must be selected.

Block 22. DENTAL: If you refuse dental when first eligible, you can enroll yourself and your dependent(s) only during an open enrollment period (every two years) or within 31 days of a special eligibility situation. For dependents to be covered, they must be listed in **Block 27** and the appropriate level of coverage must be selected.

Block 23. DENTAL PLUS: 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 24. VISION CARE: Before making a selection, refer to the plan description provided by your employer.

MEDICARE AND OTHER COVERAGE:

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: If you checked "Yes," list all dependents with other group health coverage. If you are submitting an update because a dependent no longer has other health coverage, check "No" and enter the date coverage ended.

Block 27. DEPENDENT INFORMATION: 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 not an employee or retiree of an EIP-covered employer (an employer that participates in the State of South Carolina Insurance Benefits Program. If spouse is an employee or retiree of an EIP-covered employer, check "Yes."

Legal documentation is required for all children other than natural children (i.e., grandchild, niece, nephew, foster child, brother, sister, adopted child). For a child age 19-24 to be eligible for coverage, the dependent must be a full-time student or incapacitated (documentation required). Full-time student status and continued eligibility may be audited. 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 28: Form must be signed and dated by employee within 31 days of hire or the qualifying event.

Block 29: The benefits administrator must sign and date the form and attach all documentation before submitting it to the Employee Insurance Program.