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

COBRA NOTICE OF ELECTION (NOE)
SOUTH CAROLINA PUBLIC EMPLOYEE BENEFIT AUTHORITY
INSURANCE BENEFITS

Clear Form

C
See Instructions - If Completing By Hand Use Black Ink

ELIGIBILITY

Select ONE:
- ☐ Left Employment (RIF'd, resigned, transferred, retired, called to active duty, fired)
- ☐ Had reduction in hours of employment
- ☐ Divorced ☐ Separated ☐ Dependent Child Eligibility Ended

Employee/Retiree Social Security Number (SSN) _____

Date of Qualifying Event MM/DD/YYYY

Verification of eligibility *(required of retirees from employers other than state agencies and school districts)*
(Local Subdivisions: Make sure you have received payment before sending the NOE)

Benefits Administrator Signature _____ **Employer ID** _____

ACTION

Select ONE:
- ☐ New Subscriber
- ☐ Termination Due to Non-Payment of Premiums *(otherwise, use Notice to Terminate COBRA Continuation Coverage)*
- ☐ Change *(Specify)* _____

Date of Change Event _____ SSN Change - Incorrect # _____ *(Attach Copy of Social Security Card)*

Name Change - Prior Name _____

PEBA INSURANCE BENEFITS USE ONLY

Employer ID _____

Effective Date _____

Group ID# _____

ENROLLEE INFO

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	8. Marital Status	9. Home Phone #	10. E-mail Address
☐ M ☐ F	☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ 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
- ☐ Refuse
- ☐ Standard
- ☐ Savings
- ☐ Medicare Supplement

COVERAGE LEVEL *(Select One)*
- ☐ Subscriber ☐ Family
- ☐ Subscriber/Child(ren)
- ☐ Subscriber/Spouse
- ☐ Child Only

18. STATE DENTAL PLAN
- ☐ Refuse ☐ Subscriber
- ☐ Subscriber/Spouse
- ☐ Subscriber/Child(ren)
- ☐ Family
- ☐ Child Only

19. DENTAL PLUS *(Select One)*
- ☐ Refuse ☐ Yes

You must be enrolled in the State Dental Plan to select Dental Plus.

20. VISION CARE *(Select One)*
- ☐ Refuse ☐ Subscriber
- ☐ Subscriber/Spouse
- ☐ Subscriber/Child(ren)
- ☐ Family
- ☐ Child Only

MEDICARE

21. 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	Effective Date Part B MM/DD/YYYY
		☐ Age ☐ Disability ☐ Renal Disease		
		☐ Age ☐ Disability ☐ Renal Disease		
		☐ Age ☐ Disability ☐ Renal Disease		
		☐ Age ☐ Disability ☐ Renal Disease		

DEPENDENTS

22. Always list spouse. List eligible children to be covered. If they are not listed, they will not be covered. For children older than 25 to be eligible for coverage, submit an Incapacitated Child Certification Form.

Add (A) or Delete (D)	Dependent SSN#	Last Name	First Name	Sex M/F	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

CERTIFICATION & AUTHORIZATION

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 COBRA NOTICE OF ELECTION (NOE)

You must complete a Tobacco Certification form whenever the status of tobacco use changes for you or a dependent covered under your health insurance.

ELIGIBILITY: Indicate the reason you are enrolling under COBRA for the first time. New COBRA enrollees should also indicate date of the qualifying event (i.e., date left employment, disability approved by Social Security, divorce, child ineligible, etc.). If you are already enrolled in COBRA and are making a change, skip to the Action section.

ACTION: If you are enrolling in COBRA for the first time, select "New Subscriber." If you are already enrolled and are making a change, select "Change" and enter the type of change and date of the change event.

ENROLLEE INFORMATION: Blocks 1-16 must be completed for all transactions, including termination of coverage. If coverage is for dependent children only, enrollee information should be for the youngest child or, if applicable, for a child covered under Medicare; additional children should be included as dependents in **block 22**. **In block 16**, enter the county code of your mailing address.

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 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 only during designated enrollment periods (exception: changing plans due to eligibility for Medicare). The Savings Plan is available only to non-Medicare-eligible enrollees and dependents. If you refuse health coverage or fail to enroll yourself and all eligible dependents within 31 days of eligibility, you can enroll yourself and/or your eligible dependents during an open enrollment period or within 31 days of a special eligibility situation.

Block 18. DENTAL: Select level of dental coverage or "Refuse." If you refuse dental coverage or fail to enroll yourself and all eligible dependents within 31 days of eligibility, you can enroll yourself and/or your eligible dependents during an open enrollment period in an odd-numbered year or within 31 days of a special eligibility situation.

Block 19. DENTAL PLUS: Select "Yes" to enroll or "Refuse". 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 20. VISION CARE: Select a level of vision care coverage to enroll or "Refuse." If you refuse coverage or fail to enroll yourself and all eligible dependents within 31 days of eligibility, you can enroll yourself and/or your dependents during the next enrollment period (October) or within 31 days of a special eligibility situation.

Block 21: MEDICARE List yourself and any other persons to be covered who are eligible for Part A and/or Part B of Medicare. Please contact PEBA Insurance Benefits if you or your dependents are eligible for Medicare before you elect COBRA coverage.

Block 22. DEPENDENTS: Legal documentation is required for all dependents. List spouse and indicate whether he is an employee or retiree of a PEBA Insurance Benefits-covered employer. 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. List all dependents to be covered. If they are not listed, they will not be covered. 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: Read this block carefully, sign and date form. Send the original form and copies of any required documentation to PEBA Insurance Benefits, P.O. Box 11661, Columbia, SC 29211. Keep a copy for your records.