IB03

STATUS CHANGE FORM

Rev. 9/22

A. Subscriber Information

Name (First, Middle Initial, Last):			Gender:	Social Security Number:		Effective Date of Change:
Street Address:			City:		State:	ZIP Code:
Home Phone Number:	Cell Phone Number:	Work Phone Number:	E-Mail Address:			
Change Address and/or other information as noted above ☐			Medicare Number (if applicable):			

B. Status Change

(check all boxes requiring a change to existing coverage)

Coverage Type:	SEHIP	Medicare Advantage	Supplemental	Optional	BCBS Dental	Southland Dental	Southland Cancer	Southland Vision	PCO	Limited Purpose HRA
Cancel coverage										
Change from single to family coverage (complete Section C)										
Add dependent(s) listed below to family coverage (complete Section C)										
Change from family to single coverage (active employees must also complete Revoke Election Form – IB09)										
Cancel dependent(s) listed below from family coverage (complete Section C)										

Reason for Status Change(s) (check all that apply and provide documentation listed in parentheses):

Open enrollment – change effective January 1st	Marriage (marriage certificate within 60 days of qualifying event)
Adoption of child (adoption papers within 60 days of qualifying event)	Marriage of dependent child
Birth of a child (birth certificate within 60 days of qualifying event)	Termination of member/spouse/dependent employment
Death of spouse/dependent: Date: _________________	Commencement of spouse/dependent employment
Qualifying loss of coverage (proof of loss of coverage within 60 days of qualifying event)	Spouse's employer with different open enrollment period
Divorce/Annulment/Legal Separation (divorce decree within 60 days of qualifying event)	Medicare/Medicaid entitlement (copy of card)
Legal custody of a child (legal custody papers within 60 days of qualifying event)	Adding former state employee: Last work day: _______________
Date Change Occurred: ________________	Other ____

C. Dependent Information - Attach Separate Sheet, if necessary

First Name Middle Initial Last Name	Relationship to Employee*	Gender	Date of Birth	Social Security Number

* Documentation of relationship to employee is required for all plans except Supplemental Coverage Plan (e.g., social security number, marriage certificate, birth certificate, court decree). **IMPORTANT:** To be eligible for the non-tobacco and/or wellness discount, you must submit a completed Non-Tobacco User Discount Application and meet the requirements of the Wellness Program. When adding a spouse to SEHIP coverage, a spousal surcharge of $50 per month will be applied. To receive a discount you must submit a completed Spousal Surcharge Waiver Application (IB25). Forms are available at www.alseib.org.

AFFIRMATION AND RELEASE

I hereby affirm that I have completely read and fully understand the terms and conditions of this form. I attest that all the representations made by me on this form are true and correct. I understand that any misrepresentation may result in the forfeiture of insurance coverage and that I will be personally liable for all claims related to such misrepresentation. I further understand that there is mandatory utilization review and I do hereby give permission to release any information necessary to evaluate, administer, and process claims for benefits to any person, entity, or representative acting on the State's behalf.

Employee Signature: ____ Date: ___________________________________

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