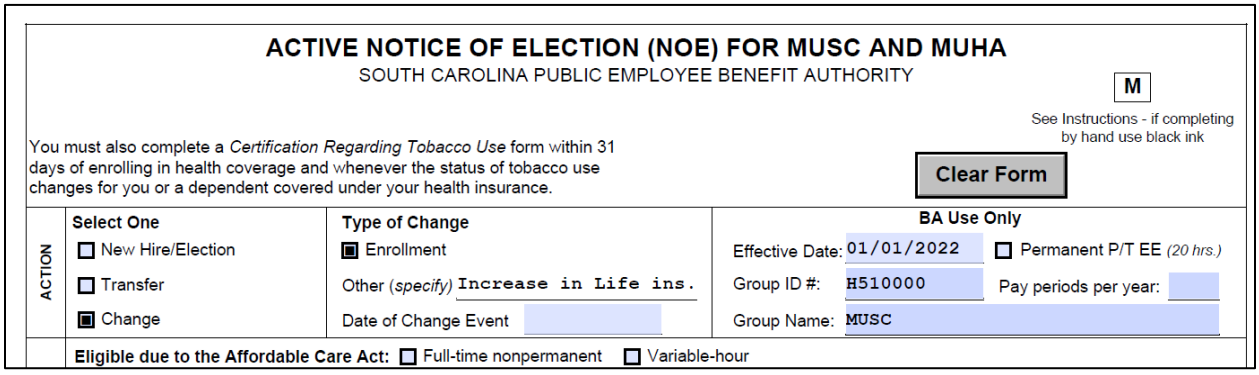
How to complete a Notice of Election form to enroll or increase Optional Life insurance during Open Enrollment period

Please follow the steps below carefully when completing the notice of election form:

a) Scan and email form to benefits@musc.edu
b) Please note that only live signatures are accepted on forms. PEBA will not accept an electronic signature. Form has to be printed, signed, scanned and emailed to the Benefits department for processing.

Steps to follow when completing the notice of election form:

1) Action-Select "**Change" Box**
2) Enrollment- Other Specify-"**Increase in Life insurance' Or "Life Insurance"**
3) BA use-Effective date-**01-01-2022**, Group #**H510000** and Group name is **MUSC**



ACTIVE NOTICE OF ELECTION (NOE) FOR MUSC AND MUHA
SOUTH CAROLINA PUBLIC EMPLOYEE BENEFIT AUTHORITY

M

See Instructions - if completing by hand use black ink

You must also complete a *Certification Regarding Tobacco Use* form within 31 days of enrolling in health coverage and whenever the status of tobacco use changes for you or a dependent covered under your health insurance.

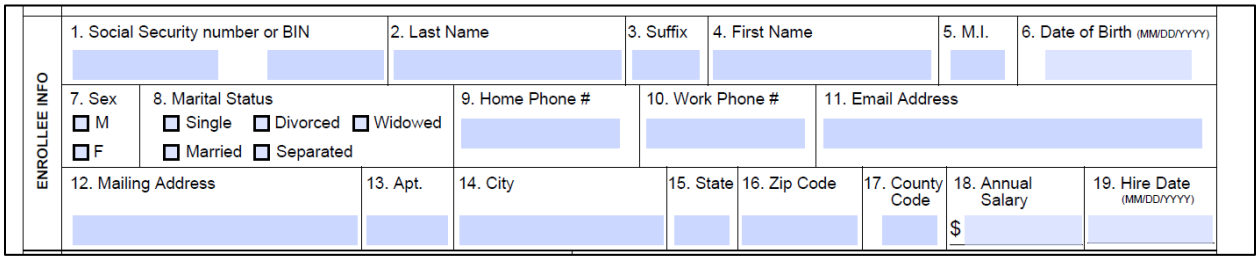
Clear Form

ACTION

Select One	Type of Change	BA Use Only
☐ New Hire/Election	■ Enrollment	Effective Date: 01/01/2022 ☐ Permanent P/T EE *(20 hrs.)*
☐ Transfer	Other *(specify)* Increase in Life ins.	Group ID #: H510000 Pay periods per year:
■ Change	Date of Change Event	Group Name: MUSC

Eligible due to the Affordable Care Act: ☐ Full-time nonpermanent ☐ Variable-hour

4) Complete section 1 through section 19 with your information



ENROLLEE INFO

1. Social Security number or BIN	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. Work Phone #	11. Email Address
☐ M ☐ F	☐ Single ☐ Divorced ☐ Widowed ☐ Married ☐ Separated			

12. Mailing Address	13. Apt.	14. City	15. State	16. Zip Code	17. County Code	18. Annual Salary	19. Hire Date (MM/DD/YYYY)
						$	

5) Check off **only Box 24-Optional life-coverage amount-Write the new coverage amount for life insurance that you are requesting. Please note that amount can only be in increment of $10,000. Please leave all other coverage boxes blank.**

COVERAGE

20. HEALTH PLAN *(Refuse or select one plan and one level of coverage)*

PLAN	COVERAGE LEVEL
☐ Refuse	☐ Employee
☐ MUSC Health Plan	☐ Employee/Spouse
☐ TRICARE Supplement	☐ Employee/Child(ren)
	☐ Family

21. DENTAL *(Refuse or select one plan and one level of coverage)*

PLAN	COVERAGE LEVEL
☐ Refuse	☐ Employee
☐ Dental Plus	☐ Employee/Spouse
☐ Basic Dental	☐ Employee/Child(ren)
	☐ Family

22. DEPENDENT LIFE Child(ren) *(select one)*
☐ Refuse
☐ $15,000

23. DEPENDENT LIFE Spouse *(select one)*
☐ Refuse
☐ Total Coverage Amount
$ _____

24. OPTIONAL LIFE *(select one)*
☐ Refuse
☐ Total Coverage Amount
$ _____

25. SUPPLEMENTAL LTD *(select one)*
☐ Refuse
☐ Plan One - *90-day waiting period*
☐ Plan Two - *180-day waiting period*

26. VISION CARE *(select one)*
☐ Refuse
☐ Employee
☐ Employee/Spouse
☐ Employee/Child(ren)
☐ Family

6) Initial and date first page

EMPLOYEE INITIALS _____ **DATE** _____

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7) Write your social security number, last name and first name on top of notice of election form

Social Security number: _____ **BIN:** _____ **Last Name:** _____ **First Name:** _____

8) List spouse in section 30 if married. There is no need to list all your dependents. This is solely for life insurance increase.

DEPENDENTS

30. Always list spouse. List eligible children to be covered. If they are not listed, they will not be covered. For a child age 19-24 to be eligible for Dependent Life-Child coverage, your child must be eligible according to the requirements on the instructions page for this NOE.

Add (A) or Delete (D)	Dependent SSN	Last Name	First Name	Sex	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
	Child						☐Incapacitated

9) Sign and date form no later than October 31, 2021. Signature must be a live signature. Upon receipt of form, Benefits Administrator will sign notice of election form. The benefits administrator will submit a Statement of Health Request in the Electonic Benefits System to initiate the online process. Upon receipt of an approval notice from the Metlife underwriting department, your notice of election form and approval notice from Metlife will be mailed to PEBA insurance for processing. **The change will be effective January 1, 2022.**

CERTIFICATION & AUTHORIZATION

31. 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 certify that any child enrolled in Dependent Life/Child insurance is eligible according to the requirements on the reverse of this NOE. I also understand that proof of eligibility (at the time of enrollment and at the time of the claim) will be required before any Dependent Life/Child insurance claim is paid. 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. 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 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. I further acknowledge that the eligibility status of any covered individual is subject to audit at any time.

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 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.

Employee Signature _____ Date _____

32. 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.

Benefits Administrator Signature _____ Phone _____ Date _____