HORRY GEORGETOWN TECHNICAL COLLEGE

TO: New Full-Time (FTE) Employee

FROM: Tara Lahnen, Assistant HR Director and Benefits Manager
Horry Georgetown Technical College

Re: PEBA Insurance and Retirement Benefits

Welcome to HGTC, I look forward to meeting you at your Benefits Orientation! In an effort to expedite the Orientation paperwork process, there is information related to your insurance benefit and retirement options on our website under Human Resources – Benefits – New Hire Information. Please feel free to contact me if you have any questions regarding the posted information. I will contact you in the near future to schedule your benefit orientation - the orientation generally takes around 30-45 minutes.

Please be prepared to discuss your election options regarding your choice of Health, Dental, Optional Life, Dependent Life Spouse and/or Child, and Supplemental Long Term Disability. You do have **31** days from date of hire to make these selections, so you are able to change anything that you do choose or add anything you've refused at orientation. An overview of the current ***Insurance Orientation*** can be viewed at www.eip.sc.gov. Choose your category – Active Subscriber – Presentations; the direct link is also on our New Hire Information webpage under 'Insurance.' We will review the Employee Insurance Program's (EIP) worksheet during your orientation.

Membership in one of the Retirement Plans outlined below (SCRS or State ORP) is mandatory for all full-time employees. You have **30** days from your date of hire to make a selection. We have posted on our New Hire webpage under 'Retirement' for your review, a *Select Your Retirement Plan* brochure. This brochure, along with the information provided in your scheduled Benefits Orientation, will help you in your selection of a retirement plan.

RETIREMENT (All new employees hired on or after July 1, 2002 may elect SCRS or State ORP.)

SC Retirement System

- Defined Benefit Plan; the State bears the investment risk and provides a guaranteed monthly pension based on a statutory formula, not on your account balance.
- Members contribute 8.00% of his/her gross salary, effective July 1, 2014.

Optional Retirement Programs

- Defined Contribution Plan. In a defined contribution plan, you invest your funds within the plan's investment choices and then bear the risk, or enjoy the benefit, based on the performance of your investments. Your retirement benefit is based on the balance in your account when you retire.
- Members contribute 8.00% of his/her gross salary, effective July 1, 2014.
- There are four types of Optional Retirement Programs available and they are VALIC, METLIFE, TIAA-CREF, and MassMutual.

If you should have any questions, please do not hesitate to contact me by phone at (843) 349-5213, email Tara.Lahnen@hgtc.edu or stop by the Human Resources Department located on the Conway, Building 200. I look forward to seeing you in the near future at our scheduled Benefits Orientation, and again, Welcome to HGTC!

Comparison of Health Plan Benefits Offered for 2015[1]

This chart is for comparison purposes only. For more information on these plans, please refer to your 2014 *Insurance Benefits Guide*.					
Plan	**SHP Savings Plan**		**SHP Standard Plan[2]**		**Medicare Supplemental Plan[2]**
Availability	Coverage worldwide		Coverage worldwide		Same as Medicare Available to retirees and covered dependents/survivors who are eligible for Medicare
Active Employee Monthly Premiums	**Tobacco users will pay a $40- or $60-per-month surcharge *in addition* to their health premium.[5]**				
Subscriber Only *Subscriber/Spouse* *Subscriber/Children* *Full Family*	**$ 9.70** **$ 77.40** **$ 20.48** **$113.00**		**$ 97.68** **$253.36** **$143.86** **$306.56**		**Refer to the "Premiums" page of the PEBA Insurance Benefits website for applicable rates.**
	Please note that premiums for optional employer groups, such as local subdivisions, may vary. To verify your rates, contact your benefits office.				
Annual Deductible *Single* *Family*	**(no copayments)** **$3,600** **$7,200[3]**		**$445** **$890**		Pays Medicare Part A and Part B deductibles
Coinsurance	**In-network** Plan pays 80% You pay 20%	**Out-of-network** Plan pays 60% You pay 40%	**In-network** Plan pays 80% You pay 20%	**Out-of-network** Plan pays 60% You pay 40%	Pays Part B coinsurance of 20%
Coinsurance Maximum *Single* *Family*	**$2,400** **$4,800** **(excludes deductible)**	**$4,800** **$9,600** **(excludes deductible)**	**$2,540** **$5,080** **(excludes deductible and copayments)**	**$ 5,080** **$10,160** **(excludes deductible and copayments)**	None
Physicians Office Visits	Chiropractic payments limited to **$500** a year, per person		Chiropractic payments limited to **$2,000** a year, per person		Pays Part B coinsurance of 20%
	No copayments		**$12** copayment, then:		
	In-network Plan pays 80% You pay 20%	**Out-of-network** Plan pays 60% You pay 40%	**In-network** Plan pays 80% You pay 20%	**Out-of-network** Plan pays 60% You pay 40%	
Hospitalization/ Emergency Care	No copayments		Outpatient facility services: **$95** copayment Emergency care: **$159** copayment then:		**For inpatient hospital stays**, the Plan pays: Medicare deductible; coinsurance for days 61-150; (Medicare benefits may end sooner if the member has previously used any of his 60 lifetime reserve days); 100% beyond 150 days (Medi-Call approval required)
			In-network Plan pays 80% You pay 20%	**Out-of-network** Plan pays 60% You pay 40%	**For skilled nursing facility care**, the Plan pays coinsurance for days 21-100; 100% of approved days beyond 100 days, up to 60 days per year.
Prescription Drugs	Participating pharmacies and mail order only: You pay the State Health Plan's allowed amount until the annual deductible is met. Afterward, the Plan will reimburse 80% of the allowed amount; you pay 20% in coinsurance. When the coinsurance maximum is reached, the Plan will reimburse 100% of the allowed amount.		Participating pharmacies only (up to 31-day supply): **$9** Tier 1 (generic-lowest cost alternative), **$38** Tier 2 (brand-higher cost alternative), **$63** Tier 3 (brand-highest cost alternative) Mail order and Retail Maintenance Network pharmacies (up to 90-day supply): **$22** Tier 1, **$95** Tier 2, **$158** Tier 3 Copay maximum: **$2,500**		Participating pharmacies only (up to 31-day supply): **$9** Tier 1 (generic-lowest cost alternative), **$38** Tier 2 (brand-higher cost alternative), **$63** Tier 3 (brand-highest cost alternative) Mail order and Retail Maintenance Network pharmacies (up to 90-day supply): **$22** Tier 1, **$95** Tier 2, **$158** Tier 3 Copay max: **$2,500**

[1] Premiums for subscribers of optional employer groups (such as cities, counties and other local subdivisions) may increase, decrease or remain the same, based on the group's rating. If you are a subscriber of an experience-rated group, your benefits office will announce next year's rates.

[2] Refer to your 2014 *Insurance Benefits Guide* for information on how this plan coordinates with Medicare.

[3] If more than one family member is covered, no family member will receive benefits, other than preventive, until the $7,200 annual family deductible is met.

[4] State Health Plan subscribers who use tobacco or cover dependents who use tobacco will pay a $40-per-month surcharge for subscriber-only coverage. The surcharge is $60 for other levels of coverage.

NOTICE OF HIPAA SPECIAL ENROLLMENT RIGHTS

You are eligible to participate in the health insurance plans offered through PEBA Insurance Benefits. To actually participate, you must complete a Notice of Election form and pay the premium.

The Health Insurance Portability and Accountability Act ("HIPAA") requires PEBA Insurance Benefits to notify you of a very important provision in its health insurance plan. You have the right to enroll in PEBA Insurance Benefits' health insurance plans under its "special enrollment provision" if you acquire a new dependent or if you decline coverage under PEBA Insurance Benefits' health insurance plans for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

I. SPECIAL ENROLLMENT PROVISION

- **Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program [CHIP]).** If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in PEBA Insurance Benefits' health insurance plans if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment **within 31 days** after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

- **Loss of Coverage for Medicaid or a State Children's Health Insurance Program (CHIP).** If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in PEBA Insurance Benefits' health insurance plans if you or your dependents lose eligibility for that other coverage. However, you must request enrollment **within 60 days** after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

- **New Dependent by Marriage, Birth, Adoption or Placement for Adoption.** If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your new dependents in PEBA Insurance Benefits' health insurance plans. However, you must request enrollment **within 31 days** after the marriage, birth, adoption or placement for adoption.

- **Eligibility for Medicaid or a State Children's Health Insurance Program (CHIP).** If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program, you may be able to enroll yourself and your dependents in PEBA Insurance Benefits' health insurance plans. However, you must request enrollment **within 60 days** after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about special enrollment provisions in PEBA Insurance Benefits' health insurance plans, contact your Benefits Administrator [Tara Lahnen, Benefits Manager, 2050 Hwy 501 East, Conway, SC 29526 843.349.5213].

II. PREMIUM ASSISTANCE:

If you live in one of the States on the attached list, you may be eligible for assistance paying your employer health plan premiums. The attached list of States is current as of November 3, 2010. You should contact your State for further information on eligibility.

To see if any more States have added a premium assistance program since November 3, 2010, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
1-866-444-EBSA (3272) www.dol.gov/ebsa

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
1-877-267-2323, Ext 61565 www.cms.hhs.gov

If you are not enrolled in Medicaid or CHIP, but think you or your dependent might be eligible, contact your State Medicaid or CHIP office, or call 1-877-KIDS-NOW or visit www.insurekidsnow.gov to apply.

CHIP ASSISTANCE:	
Arizona	1-877-764-5437 http://www.azahcccs.gov/applicants/default.aspx
Arkansas	1-888-474-8275 http://www.arkidsfirst.com
Colorado	1-303-866-3243 http://www.CHPplus.org
Idaho	1-800-926-2588 http://www.medicaid.idaho.gov
Massachusetts	1-800-462-1120 http://www.mass.gov/MassHealth
Nevada	1-877-543-7669 http://www.nevadacheckup.nv.org/
New Jersey	1-800-701-0710 http://www.njfamilycare.org/index.html
New Mexico	1-888-997-2583 http://www.hsd.state.nm.us/mad/index.html, click on Insure New Mexico
Oregon	1-877-314-5678 http://www.oregonhealthykids.gov
Virginia	1-866-873-2647 http://www.famis.org/

MEDICAID ASSISTANCE:	
Alabama	1-800-362-1504 http://www.medicaid.alabama.gov
Alaska	Outside Anchorage: 1-888-318-8890; Anchorage: 907-269-6529 http://health.hss.state.ak.us/dpa/programs/medicaid/
California	1-866-298-8443 http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx
Colorado	1-800-866-3513 http://www.colorado.gov
Florida	1-866-762-2237 http://www.fdhc.state.fl.us/Medicaid/index.shtml
Georgia	1-800-869-1150 http://dch.georgia.gov/, click "Programs" then select "Medicaid"
Idaho	1-800-926-2588 http://www.accesstohealthinsurance.idaho.gov
Indiana	1-877-438-4479 http://www.in.gov/fssa/2408.htm
Iowa	1-888-346-9562 www.dhs.state.ia.us/hipp/
Kansas	1-800-766-9012 https://www.khpa.ks.gov
Kentucky	1-800-635-2570 http://chfs.ky.gov/dms/default.htm
Louisiana	1-888-342-6207 http://www.lahipp.dhh.louisiana.gov
Maine	1-800-321-5557 http://www.maine.gov/dhhs/oms/
Massachusetts	1-800-462-1120 http://www.mass.gov/MassHealth
Minnesota	Outside Twin City area: 1-800-657-3739; Twin City area: 1-651-431-2670 http://www.dhs.state.mn.us/, click on Health Care, then Medical Assistance
Missouri	1-573-751-6944 http://www.dss.mo.gov/mhd/index.htm
Montana	1-800-694-3084 http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml
Nebraska	1-877-255-3092 http://www.dhhs.ne.gov/med/medindex.htm
Nevada	1-800-992-0900 http://dwss.nv.gov/

New Hampshire	1-603-271-4238 http://www.dhhs.nh.gov/ombp/index.htm
New Jersey	1-800-356-1561 http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
New Mexico	1-888-997-2583 http://www.hsd.state.nm.us/mad/index.html
New York	1-800-541-2831 http://www.nyhealth.gov/health_care/medicaid/
North Carolina	1-919-855-4100 http://www.nc.gov
North Dakota	1-800-755-2604 http://www.nd.gov/dhs/services/medicalserv/medicaid/
Oklahoma	1-888-365-3742 http://www.insureoklahoma.org
Oregon	1-877-314-5678 http://www.oregonhealthykids.gov
Pennsylvania	1-800-644-7730 http://www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm
Rhode Island	1-401-462-5300 http://www.dhs.ri.gov
South Carolina	1-888-549-0820 http://www.scdhhs.gov
Texas	1-800-440-0493 https://www.gethipptexas.com/
Utah	1-866-435-7414 http://health.utah.gov/medicaid/
Vermont	1-800-250-8427 http://ovha.vermont.gov/
Virginia	1-800-432-5924 http://www.dmas.virginia.gov/rcp-HIPP.htm
Washington	1-800-562-3022, ext. 15473 http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm
West Virginia	1-304-342-1604 http://www.wvrecovery.com/hipp.htm
Wisconsin	1-800-362-3002 http://dhs.wisconsin.gov/medicaid/publications/p-10095.htm
Wyoming	1-307-777-7531 http://www.health.wyo.gov/healthcarefin/index.html

You must also complete a Tobacco Certification 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.

ACTIVE EMPLOYEE NOTICE OF ELECTION (NOE)

SOUTH CAROLINA PUBLIC EMPLOYEE BENEFIT AUTHORITY
INSURANCE BENEFITS

Clear Form

A
See Instructions - If Completing By Hand Use Black Ink

ACTION

Select One:	Type of Change	BA Use Only	MoneyPlus Pretax Premiums
☐ New Hire ☐ Transfer ☐ Change	☐ Enrollment Other *(specify)* _____ Date of Change Event: _____	Effective Date: _____ ☐ Permanent P/T EE *(20 hrs.)* Group ID #: _____ Group Name: _____	☐ Refuse ☐ Yes

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. Work Phone #	11. E-mail Address
☐ M ☐ F	☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated	( )	( )	

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

MEDICARE

20. 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		☐ ☐

COVERAGE

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

PLAN ☐ Refuse ☐ TRICARE Supplement ☐ Standard ☐ Savings

Basic Life and Basic Long Term Disability included automatically with Standard and Savings plans

COVERAGE LEVEL ☐ Employee ☐ Employee/Child(ren) ☐ Employee/Spouse ☐ Family

22. STATE DENTAL PLAN *(Select One)*
☐ Refuse ☐ Employee ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Family

23. DENTAL PLUS *(Select One)*
☐ Refuse ☐ Yes

24. DEPENDENT LIFE - Child(ren) *(Select One)*
☐ Refuse ☐ $15,000

25. DEPENDENT LIFE - Spouse *(Select One)*
☐ Refuse ☐ Coverage Level $_____ *(Must be in increments of $10,000)*

26. OPTIONAL LIFE *(Select One)*
☐ Refuse ☐ Coverage Level $_____ *(Must be in increments of $10,000)*

27. SUPPLEMENTAL LTD *(Select One)*
☐ Refuse ☐ Plan One - *90-day benefit waiting period* ☐ Plan Two - *180-day benefit waiting period*

28. VISION CARE *(Select One)*
☐ Refuse ☐ Employee ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Family

BENEFICIARIES

In blocks 29 and 30, if there are additional beneficiaries or dependents, list on separate sheet, signed and dated by employee.

29. Basic Life/Optional Life *(Select one or both)*	SSN#	Last Name	First Name	Relationship	Date of Birth MM/DD/YYYY	Primary or Contingent?
☐ Basic Life ☐ Optional Life						☐ Primary ☐ Contingent
☐ Basic Life ☐ Optional Life						☐ Primary ☐ Contingent
☐ Basic Life ☐ Optional Life						☐ Primary ☐ Contingent

If beneficiary is an estate or trust, complete the following:

Estate/Trust_____ Address_____ If Trust, Date Signed_____

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 reverse of this NOE.

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						☐ Full-time Student ☐ Incapacitated
	Child						☐ Full-time Student ☐ Incapacitated
	Child						☐ Full-time Student ☐ Incapacitated

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 _____ Date _____

INSTRUCTIONS FOR COMPLETING THE ACTIVE NOTICE OF ELECTION (NOE)

IF COMPLETING BY HAND, USE BLACK INK

You must also complete a Tobacco Certification 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.

ACTION: Indicate type of action. MoneyPlus: Premiums for health, dental, vision and Optional Life up to $50,000 are deducted on a pretax basis unless refused. There is an administrative fee for the pretax deductions. Pretax MoneyPlus changes must be made during enrollment or within 31 days of a qualifying change in status event.

Blocks 1-19. ENROLLEE INFORMATION: Must be completed for all transactions, including a refusal of coverage.

Block 20. MEDICARE: List yourself and any other persons to be covered who are eligible for Part A and/or Part B of Medicare.

COVERAGE: Alterations (such as mark-throughs or white out) in this section are not allowed. To enroll, select the coverage and select the coverage level, if applicable. To refuse or cancel coverage, select "Refuse."

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 enroll yourself and/or your dependent(s) only during an open enrollment period or within 31 days of a special eligibility situation. If health coverage is refused, benefits for Basic Life and Basic Long Term Disability are forfeited.

To select a health plan, 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 30, and the appropriate level of coverage must be selected.

Block 22. DENTAL: If you refuse dental when first eligible, you can apply for coverage for yourself and your dependent(s) only during an open enrollment period during an odd-numbered year or within 31 days of a special eligibility situation. For dependents to be covered, they must be listed in Block 30, 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. DEPENDENT LIFE—CHILD(REN): For child(ren) to be covered for Dependent Life Insurance, they must be listed in **Block 30**. To be eligible, they must be unmarried; must be supported by you; must not be employed on a full-time basis; and must not be in the military. In addition, for a child age 19-24 to be eligible the child must be certified by the PEBA Insurance Benefits as incapacitated at the time of enrollment or must be a full-time student at an accredited school, college or university. Children older than 24 must be certified by PEBA Insurance Benefits as incapacitated to be enrolled in Dependent Life-Child. Proof of eligibility, at the time of enrollment and at the time of the claim, will be required before any benefit will be paid.

Block 25. DEPENDENT LIFE—SPOUSE: Before making a selection, refer to the detailed instructions provided by your employer.
To select coverage, check "Coverage Level" and enter the amount of coverage for your spouse, not to exceed 50 percent of your current level of Optional Life, or $100,000. Approved medical evidence of good health is required if coverage exceeds $20,000. For your spouse to be covered, he must be listed in **Block 30.**

Block 26. OPTIONAL LIFE: Before making a selection, refer to the detailed instructions provided by your employer.

To select coverage, check "Coverage Level" and enter the amount of coverage. Coverage level may be based on your current salary (newly enrolled), a guaranteed issue and/or approved medical evidence of good health. If you do not enroll within 31 days of your date of hire, medical evidence of good health must be provided and approved to enroll or increase coverage level. However, if enrolled in the MoneyPlus Pretax Premium Feature, you must wait until the next enrollment period or within 31 days of a special eligibility situation.

Block 27. SUPPLEMENTAL LONG TERM DISABILITY: Before making a selection, refer to the detailed instructions provided by your employer.

Check only one block. If changing from "Plan Two" to "Plan One," medical evidence of good health must be provided.

Block 28. VISION CARE: Before making a selection, refer to the plan description provided by your employer.

Block 29. BENEFICIARIES: List a beneficiary for Basic Life if enrolled in health coverage and Optional Life if selected. Multiple beneficiaries may be listed. Beneficiaries must be listed individually by a name or organization. Unless otherwise provided herein, if two or more beneficiaries are named, the proceeds shall be paid in equal shares to the named survivors. Contingent beneficiaries have no rights unless all primary beneficiaries have died.

Block 30. DEPENDENTS: Legal documentation is required for all dependents. 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 he is not an employee or retiree of an employer that participates in the State of South Carolina Insurance Benefits Program. If your spouse is an employee or retiree of a PEBA Insurance Benefits-covered employer, check "Yes."

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: Form must be signed and dated by employee within 31 days of hire or the qualifying event.

The benefits administrator must sign and date form and attach copies of all supporting documentation before submitting it to the **PEBA Insurance Benefits at P.O. Box 11661 Columbia, SC 29211-1661.**

SOUTH CAROLINA PUBLIC EMPLOYEE BENEFIT AUTHORITY
Insurance Benefits

Certification Regarding Tobacco Use

SUBSCRIBER NAME:	SUBSCRIBER BIN OR SSN:	EMPLOYER GROUP NUMBER:

NON-TOBACCO-USER PREMIUM

- ❑ I certify that I am eligible for the Non-Tobacco-User Premium by **checking this box** and returning this form to PEBA Insurance Benefits. By checking this box, I certify the truth and understanding of the following:
  - ❖ I certify that all persons covered by my health insurance through PEBA Insurance Benefits (including myself and any dependents) are not currently using, and have not used, any tobacco products in any form (cigarettes, cigars, pipe, oral tobacco products, etc.) within the last 6 months.
  - ❖ I certify that if this information changes at any time in the future, while I have health insurance coverage through PEBA Insurance Benefits, I will notify PEBA Insurance Benefits of such change within 30 days through completion and re-submission of this form.
  - ❖ I certify that this information is true and correct to the best of my knowledge.
  - ❖ **I understand that if it is determined that I (or any of my covered dependents) have used tobacco products within the last 6 months or if I (or any of my covered dependents) start using tobacco products after the date of this certification without notifying PEBA Insurance Benefits, I will be subject to penalties including, but not limited to, payment of the premium difference since last certification, plus a 10% penalty and elimination of the tobacco user's out-of-pocket maximum for the current year and following year.**
  - ❖ I understand that this change in premiums will be prospective (apply only to premiums I pay in the future). I will not be refunded any part of the Tobacco-User Premium I have already paid.

TOBACCO-USER PREMIUM

- ❑ I acknowledge that I will pay the Tobacco-User Premium by **checking this box**. I declare that one or more persons covered by my health insurance through PEBA Insurance Benefits uses tobacco products in some form or that I choose not to disclose my status as it relates to tobacco use. I understand that by checking this box I will pay the Tobacco-User Premium.

_____ _____
SUBSCRIBER SIGNATURE DATE

_____ _____
BENEFITS ADMINISTRATOR SIGNATURE DATE

THE LANGUAGE USED IN THIS DOCUMENT DOES NOT CREATE AN EMPLOYMENT CONTRACT BETWEEN THE EMPLOYEE AND THE AGENCY. THE AGENCY RESERVES THE RIGHT TO REVISE THE TERMS AND CONDITIONS OF THIS DOCUMENT IN WHOLE OR IN PART AT ANY TIME. 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.

 If you have any questions, please call Customer Service at 803-734-0678 or toll-free at 888-260-9430.

Return this completed form to PEBA Insurance Benefits, PO Box 11661, Columbia, SC 29211.

SCRS RETIREMENT PLAN ENROLLMENT FORM 1100

Membership in one of the Retirement Plans, SCRS or State ORP, is mandatory for all full time employees. Please **complete** Section I (1-15) only in **BLACK INK**, read 17 and **SIGN AND DATE IN BLUE INK with no mistakes.** See Reverse for Additional Instructions.

To enroll in the SCRS or the State ORP, you will need to complete both the Retirement Plan Enrollment **Form 1100** and the applicable Beneficiary Form; Form 1102 for SCRS or Form 1106 for State ORP.

SCRS RETIREMENT PLAN

Form 1102 Please complete in **BLACK INK** with no mistakes the following:

Section I, complete in full
Section II-A, must have at least one beneficiary listed
Section II-B, if you do not wish to list a beneficiary, leave blank.
Section III, must have at least one beneficiary listed

STATE OPTIONAL RETIREMENT PLANS (ORP)

Form 1106 Please complete in **BLACK INK** with no mistakes the following:

Section I, complete in full
Section II, must have at least one beneficiary listed
Section III, please sign and have notarized. The Benefits Manager, Tara Lahnen, can notarize this document for you during your benefit orientation.

The following ORP vendors will provide services and investment options to State ORP participants. Vendor information for each of the vendors below is provided on our New Hire Information webpage.

□ VALIC
Enoch Booth, 892-5558 ext. 89861

□ METLIFE
Mark Williamson, (770) 407-2424

□ MASS MUTUAL
Jimm Thompkins, 843-248-0004

□ TIAA-CREF
Enrollment Hot Line, 1-800-842-2888
www.tiaa-cref.org

SCRS RETIREE

As a working SCRS Retiree or TERI participant you will be **REQUIRED** to contribute 8.00% on all wages earned from an employer covered under the South Carolina Retirement System. Contributions are required regardless of whether the retired member is considered a full-time, part-time, temporary or permanent employee. If you are a SCRS Retiree or TERI participant, you must notify the Human Resources Department.

Effective January 2, 2013, if you retire before you reach age 62 and return to covered employment, you will be subject to a $10,000 per year earnings limitation. This earnings limitation applies regardless of your age when you return to work. Certain members are exempt from the $10,000 per year earnings limitation. These include members who retired prior to January 2, 2013, members who retire after age 62, and members who have returned to certain elected or appointed positions.

Form 1100
Revised 9/23/2014
Page 1

RETIREMENT PLAN ENROLLMENT

S.C. Public Employee Benefit Authority
Retirement Benefits
Attention: Enrollment
Box 11960, Columbia, SC 29211-1960

Print or type in black ink
Please read the instructions on Page 2 before completing this form.

ACTION REQUESTED (Check One):

- ☐ NEW ENROLLEE (First-time membership)
- ☐ OPEN ENROLLMENT (Irrevocable election from State ORP)
- ☐ CHANGE OF EMPLOYER (Transfer)/DUAL EMPLOYMENT
- ☐ CHANGE OF INFORMATION
  - ☐ Name (Prior Name): _____
    (ATTACH LEGAL DOCUMENT INDICATING NAME CHANGE
  - ☐ Address
  - ☐ SSN (Old Number): _____
  - ☐ Date of Birth

SECTION I: EMPLOYEE INFORMATION (TO BE COMPLETED BY THE EMPLOYEE)

1. Last Name & Suffix	2. First/ Middle Name	3. Social Security Number (attach copy of Social Security card only if changing SSN)	
4. Address	5. City	6. State	7. ZIP+4

8. Gender M - Male F - Female	9. Date of Birth	10. Telephone Number	11. Email Address

12. Have you ever been a member of PEBA's retirement systems? ☐ No ☐ Yes

13. If item 12 is "Yes", indicate the name(s) of your former employer: _____

Did you withdraw your contributions? ☐ No ☐ Yes

14. Do you currently have a pending refund request? ☐ No ☐ Yes

15. Are you now receiving or have you applied to receive a monthly benefit from any of PEBA's retirement systems? ☐ No ☐ Yes ☐ Application in Process

16. Retirement Plan Election (CHOOSE ONE)

☐ SCRS ☐ PORS (See Instructions) ☐ State ORP (If State ORP, please complete item 17.)
☐ JSRS (Judge, Solicitor, Circuit Public Defender, or Administrative Law Court)

17. Select State ORP Vendor

☐ MassMutual ☐ MetLife
☐ TIAA-CREF ☐ VALIC

18. An employee hired by an eligible employer (school district, higher education, technical college, state department, agency, bureau, commission, and institution) covered under the South Carolina Retirement System (SCRS), or individuals first elected to the S.C. General Assembly in and after November 2012, may elect to participate in either the traditional defined benefit plan, SCRS, or the optional defined contribution plan, State Optional Retirement Program (State ORP). The election to participate in State ORP must be made within 30 calendar days after entry into service (date of hire).

If I do not make an election within the required time, I will be considered to have elected membership in SCRS. Participants in the State ORP assume all investment risk. The election to participate in State ORP is irrevocable, except a State ORP participant may make a one-time irrevocable election to join SCRS during any open enrollment period after the first annual anniversary, but before the fifth annual anniversary of the initial enrollment in State ORP.

I understand that, unless a designated beneficiary is on file, my estate will be designated as my beneficiary until PEBA receives from me a properly executed beneficiary form.

My signature below indicates that my employer has explained the retirement plan options available to me and has provided me with access to information necessary to make an informed choice. My signature on this document confirms my retirement plan election as indicated in block 16 above.

THE LANGUAGE USED IN THIS DOCUMENT DOES NOT CREATE ANY CONTRACTUAL RIGHTS OR ENTITLEMENTS AND DOES NOT CREATE A CONTRACT BETWEEN THE MEMBER AND THE PUBLIC EMPLOYEE BENEFIT AUTHORITY. THE PUBLIC EMPLOYEE BENEFIT AUTHORITY RESERVES THE RIGHT TO REVISE THE CONTENT OF THIS DOCUMENT.

Employee's Signature _____ Date _____ Witness _____
(Required only when signed by mark)

SECTION II: EMPLOYER INFORMATION (TO BE COMPLETED BY THE EMPLOYER)

19. Employer Code	20. Employer Name	21. Please indicate if you are the employee's primary or secondary employer. ☐ Primary Employer ☐ Secondary Employer

22. Original Date of Hire with Employer listed in Items 19-20	23. Date of Membership	24. Employee's Position Title	25. Employee's Annual Salary

26. I hereby certify that the employee listed in Section I of this form is eligible for the retirement plan selected.

Employer Signature _____ Date _____

Work Telephone _____

For more information, please contact Customer Services at 803-737-6800, 800-868-9002 (within S.C. only), or www.retirement.sc.gov

INSTRUCTIONS
(PLEASE READ BEFORE COMPLETING AND SIGNING THIS FORM)

Complete this form: to enroll a new member; to change a member's employer, name, address, date of birth, or Social Security number; for employees who have had a break-in-service (those who return from a leave-without-pay status of more than 13 months); or when changing from one retirement system to another, regardless of prior membership.

ACTION REQUESTED - (CHECK APPROPRIATE BOX) (THE EMPLOYER MAKES THESE SELECTIONS.)

NEW ENROLLEE: Enrolling in the Retirement Systems for the first time.

OPEN ENROLLMENT: Irrevocable election from State ORP - Employee previously participated in State ORP, but is now irrevocably electing membership in SCRS during open enrollment period, after the first annual anniversary but before the fifth annual anniversary of the person's initial enrollment in State ORP.

CHANGE OF EMPLOYER/Dual employment: A member of the Retirement Systems transferring or accepting a position with another employer or a new hire with funds on deposit in the Retirement Systems.

CHANGE OF INFORMATION: Changing any of the listed information and to request that the Retirement Systems update its records on the employee accordingly.

Name (Prior Name): Attach a copy of the marriage license or other legal document authorizing the name change. Indicate the employee's **old name** in the space provided and list his **new name** in items 1-3 in Section I.

Address: List employee's new address (items 4-7 in Section I).

SSN (Old Number): Change/correct an employee's Social Security number by listing **old Social Security number** in the space provided and completing items 1-3 in Section I. (The employee's **new Social Security number** should be listed in item 3 in Section I). Include a copy of Social Security card with correct SSN.

Date of Birth: Change an employee's date of birth by completing items 1-9 in Section I.

SECTION I - ITEMS 1-18 INSTRUCTIONS (THE EMPLOYEE COMPLETES AND SIGNS THIS SECTION.)

Items 1 - 11: Complete items 1-11 by providing the requested information.

Item 12: Indicate if you have prior membership in any of the five retirement plans (SCRS, State ORP, PORS, GARS, or JSRS).

Item 13: If item 12 is "yes," provide the name(s) of the employer(s) for whom you worked and through which you contributed to one of PEBA's retirement systems or State ORP, and indicate whether or not you received a refund of your contributions.

Item 14: Indicate whether or not you currently have a pending refund request.

Item 15: Indicate whether or not you are receiving or have applied to receive a monthly benefit from the PEBA.

Item 16: Select the retirement plan of your choice (check appropriate box). You must be eligible for membership in the retirement plan you select. To be eligible for PORS membership, an employee must be required by the terms of his employment, by election or appointment, to preserve public order, protect life and property, and detect crimes in the state; to prevent and control property destruction by fire; be a coroner in a full-time permanent position; or be a peace officer employed by the Department of Corrections, the Department of Juvenile Justice, or the Department of Mental Health. Probate judges and coroners may elect membership in PORS. Magistrates are required to participate in PORS for service as a magistrate. PORS members, other than magistrates and probate judges, must also earn at least $2,000 per year and devote at least 1,600 hours per year to this work, unless exempted by statute. By signing this form as an employer, you are certifying that the employee meets these eligibility requirements. GARS is closed to members of the General Assembly who are first elected to serve in and after November 2012; however, these members may elect to join SCRS, State ORP, or non-membership.

Item 17: If you elected State ORP, you must check the appropriate box to indicate your vendor selection.

Item 18: Please sign and date the form after you have completed items 1-17.

Your employer will complete the remainder of the form (Section II).

SECTION II - ITEMS 19-25 INSTRUCTIONS (THE EMPLOYER COMPLETES AND SIGNS THIS SECTION.)

Items 19-20: Indicate the five-digit employer code assigned to your organization by the Retirement Systems and list the name of your organization.

Item 21: Indicate if this will be the employee's primary or secondary employer.

Item 22: List the date the employee was originally hired by the current employer.

Item 23: List the date the employee will begin making contributions to his chosen retirement plan through the current employer. If an employee is electing irrevocable membership in SCRS during the State ORP open enrollment period, the effective date must be April 1 of the current year.

Item 24: Indicate the employee's position title.

Item 25: List the employee's annual salary. If the employee is part-time, the salary may be listed as an hourly wage.

Item 26: Please sign and date the form, and provide your work telephone number so that the Enrollment staff may contact you if necessary.

Form 1102
Revised 7/6/2012
Page 1

Print or type in black ink

Please read the instructions on the reverse (Page 2) before completing this form.

ACTIVE MEMBER BENEFICIARY FORM

BENEFICIARY DESIGNATION, CONTINGENT BENEFICIARY FOR ACTIVE MEMBERS ONLY- RETIREES USE FORM 7201

SC Public Employee Benefit Authority
South Carolina Retirement Systems
P.O. Box 11960, Columbia, SC 29211-1960

Use for designation of active member beneficiaries and contingent beneficiaries. You may wish to consult with an attorney/estate planner before completing this form.

CHECK ONE:

☐ New Enrollee

☐ Change of Beneficiary

Retirement System (check one)

☐ SCRS ☐ PORS

☐ GARS ☐ JSRS

Section I **PERSONAL INFORMATION**

1. Last Name & Suffix	2. First/Middle Name	3. Social Security Number

4. Date of Birth	5. Address

6. City	7. State	8. ZIP+4

ALL SECTIONS MUST BE COMPLETED

Section II-A BENEFICIARY(IES) FOR REFUND OF CONTRIBUTIONS/SURVIVOR BENEFITS - I designate the following **PRIMARY** beneficiary(ies) to receive my Retirement Systems refund of contributions or survivor benefits if eligible.

1. Name of Beneficiary (ONE PERSON)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship
2. Name of Beneficiary (ONE PERSON)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship
3. Name of Beneficiary (ONE PERSON)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship

Section II-B Contingent Beneficiaries Have No Rights Unless All Primary Beneficiaries Have Died - I designate the following **CONTINGENT** beneficiary(ies) to receive my Retirement Systems refund of contributions or applicable survivor benefits. **If the contingent beneficiary designation below is blank all previous contingent beneficiaries will be revoked and your estate will become your contingent beneficiary.**

1. Name of Beneficiary (ONE PERSON)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship
2. Name of Beneficiary (ONE PERSON)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship
3. Name of Beneficiary (ONE PERSON)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship

Section III **BENEFICIARY(IES) FOR INCIDENTAL DEATH BENEFIT (You may not designate contingent beneficiaries for the Incidental Death Benefit). I designate the following beneficiary(ies) to receive my Retirement Systems Incidental Death Benefit:**

1. Name of Beneficiary (ONE PERSON)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship
2. Name of Beneficiary (ONE PERSON)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship
3. Name of Beneficiary (ONE PERSON)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship

Section IV **CERTIFICATION AND CONDITIONS**

IMPORTANT: Please read the Certification and Conditions sections of the instructions on the reverse (Page 2) before signing this form. I hereby certify I have read and understand the information on the reverse (Page 2), including the certification and conditions, and I agree to the provisions stated.

MEMBER'S SIGNATURE _____ WITNESS _____
(Do not print) (Required only when signed by mark)

STATE OF _____ COUNTY OF _____

Acknowledged before me this date _____ NOTARY NAME _____

My Commission Expires _____ NOTARY SIGNATURE _____
(Out of state, requires Seal)

THE LANGUAGE USED IN THIS DOCUMENT DOES NOT CREATE ANY CONTRACTUAL RIGHTS OR ENTITLEMENTS AND DOES NOT CREATE A CONTRACT BETWEEN THE MEMBER AND THE SOUTH CAROLINA RETIREMENT SYSTEMS. THE SOUTH CAROLINA RETIREMENT SYSTEMS RESERVES THE RIGHT TO REVISE THE CONTENT OF THIS DOCUMENT.

INSTRUCTIONS

USE THIS FORM FOR ACTIVE MEMBER BENEFICIARY DESIGNATIONS WHICH DO NOT REQUIRE A TRUSTEE APPOINTMENT. THIS FORM MUST BE COMPLETED IN ITS ENTIRETY EACH TIME. AN ACKNOWLEDGMENT LETTER WILL BE SENT TO THE MEMBER EACH TIME A FORM IS RECEIVED BY THE SC RETIREMENT SYSTEMS. FOR RETIREE BENEFICIARY DESIGNATION, USE FORM 7201.

Check the appropriate boxes in the upper right corner. If you are a member of more than one system, complete a beneficiary form (FORM 1102) for each system. You should complete a form for each system of which you are a member when making any beneficiary changes (i.e. if you complete a FORM 1102 for your SCRS account, beneficiary changes will be for that system only, your prior designations for your PORS account would still be in effect).

SECTION I

1-8. Complete the general information concerning yourself.

SECTION II-A REFUND OF CONTRIBUTIONS/SURVIVOR BENEFITS

On this form you may designate a person(s) or your estate as beneficiary for your retirement contributions or survivor benefits. Leave the relationship, sex, date of birth, and SSN blank if you are naming your estate as beneficiary. If you are naming your estate as beneficiary, you may not designate a person(s) for this portion of your retirement benefits. If additional space is needed to designate more than three beneficiaries, complete and attach a second FORM 1102 and indicate on the form how many pages are being submitted. That information will assist the SC Retirement Systems in determining total number of forms submitted in the event the forms are separated during the processing. **If Section II-A is left blank the Form 1102 is incomplete. The Form 1102 is marked "VOID" and returned for completion of a new form.**

NOTE: SURVIVOR BENEFITS WILL NOT BE PAID TO AN ESTATE - LUMP SUM REFUND ONLY!

SECTION II-B CONTINGENT BENEFICIARY (OPTIONAL)

In accordance with §9-1-1650, §9-9-100, and §9-11-110, Code of Laws of SC (1976) as amended, an "active" member (a member who is actively employed, making regular contributions and earning service credit) may name contingent beneficiaries to receive a refund of member contributions or survivor benefits (if eligible). **{THESE CONTINGENT BENEFICIARIES HAVE NO RIGHTS, UNLESS ALL PRIMARY BENEFICIARIES HAVE DIED}**. Contingent beneficiaries may not be designated for Incidental Death Benefit. If you do not want a contingent beneficiary, write "NONE" in Section II-B on the reverse (Page 1) of this form. **If a form is received in which the contingent beneficiary section is left blank, the designation will default to estate, even if there is a prior contingent beneficiary designation on file**.

SECTION III INCIDENTAL DEATH BENEFIT

You may name different beneficiaries for the Incidental Death Benefit (a benefit equal to your annual salary), paid in a lump sum (if the employer has elected this coverage). The $3,000 State Life Insurance and Optional Life Insurance are administered by the Employee Insurance Program (EIP); contact EIP for information pertaining to those benefits. Contact your employer or the SC Retirement Systems for Incidental Death Benefit coverage. If you do not have Incidental Death Benefit coverage, write "N/A" in Section III on the reverse (Page 1) of this form.

SECTION IV CERTIFICATION AND CONDITIONS

1. **CERTIFICATION:** This form must be signed by the member in the presence of a notary public and be properly notarized. If more than one form is completed, **ALL** forms must be notarized on the same date. **FORMS ALTERED IN THE BENEFICIARY DESIGNATION OR CERTIFICATION SECTIONS WILL NOT BE ACCEPTED.**
2. **REVOCATION:** All previous beneficiary designations to receive retirement benefits are hereby revoked.
3. **AUTHORIZATION:** I hereby authorize the SC Retirement Systems to make payment of any refund of my accumulated contributions and/or any other payment due in the event of my death prior to retirement to the beneficiary(ies) designated on the front of this form (Page 1) in accordance with the provisions of the SC Retirement Systems , and agree on behalf of myself and my heirs and assigns, that any payment so made shall be a complete discharge of the claim or claims, and shall constitute a release of the Retirement Systems from any further obligations on account of the benefit or benefits. In the event my primary beneficiary(ies) predeceases me and if a contingent beneficiary designation is on file, the SC Retirement Systems would pay any benefits due to the contingent beneficiary(ies). In the event that no primary beneficiary(ies) or contingent beneficiary(ies) are alive at the time of my death, my estate (which is ineligible for survivor benefits), will automatically become my designated beneficiary. I reserve the right to change the designated beneficiary(ies) by a written designation filed with the SC Retirement Systems in accordance with its rules and regulations.
4. **PAYMENT:** The SC Retirement Systems shall be fully discharged of liability for all amounts paid to the beneficiary(ies), and shall have no other obligation as to the application of such amounts. In any dealing with a beneficiary(ies), including but not limited to any consent, release, or waiver of interest, the SC Retirement Systems shall be fully protected against the claim or claims of every other person.
5. **MULTIPLE BENEFICIARIES:** Survivor benefits payable to two or more beneficiaries shall be calculated based upon the average age of the designated beneficiaries. Payments will be equally divided among surviving beneficiaries at the member's death.

Please contact Customer Services with any questions: (803)737-6800, (800)868-9002 (within SC only) or www.retirement.sc.gov.

Form 1106
Revised 7/6/2012

STATE ORP ACTIVE INCIDENTAL DEATH BENEFIT BENEFICIARY DESIGNATION

South Carolina Retirement Systems
SC Public Employee Benefit Authority
Attention: Enrollment
P.O. Box 11960, Columbia SC 29211-1960

Print or type in black ink

Please read the instructions on Page 2 before completing this form.

CHECK ONE:
☐ State ORP New Enrollee
☐ State ORP Active Incidental Death Benefit Beneficiary Change

Section I — PERSONAL INFORMATION

1. Last Name & Suffix	2. First/Middle Name	3. Social Security Number

4. Date of Birth	5. Address

6. City	7. State	8. ZIP+4

Section II — BENEFICIARY(IES) FOR ACTIVE INCIDENTAL DEATH BENEFIT

I designate the following beneficiary(ies) to receive the State ORP Group Life Insurance:

1. Name of Beneficiary (ONE PERSON)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship
2. Name of Beneficiary (ONE PERSON)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship
3. Name of Beneficiary (ONE PERSON)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship
4. Name of Trustee(s)	Trust ID, if applicable	Address of Trustee(s)		
Name of Trust Beneficiary (ONE PERSON)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship
Name of Trust Beneficiary (ONE PERSON)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship

Section III — CERTIFICATION AND CONDITIONS

IMPORTANT:
Please read the Certification and Conditions section of the instructions on Page 2 before signing this form. I hereby certify I have read and understand the information on Page 2, including the certification and conditions, and I agree to the provisions stated.

MEMBER'S SIGNATURE _____ WITNESS _____
(Do not print) (Required only when signed by mark)

STATE OF _____ COUNTY OF _____

ACKNOWLEDGED BEFORE ME THIS DATE_____ NOTARY NAME _____

MY COMMISSION EXPIRES_____ NOTARY SIGNATURE _____
(Out of state, requires Seal)

Please contact Customer Services with any questions at (803)737-6800, (800) 868-9002 (within SC only), or www.retirement.sc.gov.

INSTRUCTIONS

USE THIS FORM FOR STATE ORP BENEFICIARY DESIGNATIONS. THIS FORM MUST BE COMPLETED IN ITS ENTIRETY EACH TIME A BENEFICIARY DESIGNATION IS MADE OR CHANGED.

SECTION I

Complete this section by providing the requested information for items 1-8.

SECTION II

STATE ORP ACTIVE INCIDENTAL DEATH BENEFIT - If your State ORP employer has elected Incidental Death Benefit coverage and you die in service with at least one year of service credit, a payment equal to your current annual salary will be paid to your designated beneficiaries or trustees. If your death is the result of a job-related injury, the one-year requirement is waived. Complete this section to designate or change your beneficiary(ies) for your Incidental Death Benefit. You may designate one or more beneficiaries. If you designate more than one beneficiary, total benefits will be divided equally among them and each beneficiary will receive the same amount. If you are designating benefits to be paid through a trust, please complete the information in Section II, item 4 on Page 1. If you are designating more than three beneficiaries, complete and attach an additional Form 1106, please write the total number of pages you are submitting on each Form 1106 in the space at the bottom left corner of Page 1.

SECTION III

CERTIFICATIONS AND CONDITIONS

1. CERTIFICATION: The member must appear before a notary public to acknowledge signing this form, and the form must be properly notarized. If more than one form is completed, **ALL** forms must be notarized on the same date. **FORMS ALTERED IN THE BENEFICIARY DESIGNATION OR CERTIFICATION SECTIONS WILL NOT BE ACCEPTED.**

2. REVOCATION: All previous State ORP Active Incidental Death Benefit beneficiary designations are hereby revoked.

3. AUTHORIZATION: I hereby authorize the SC Retirement Systems to make payment of State ORP Incidental Death Benefit in the event of my death during State ORP active employment to the beneficiary(ies) designated on this form in accordance with the provisions of the SC Retirement Systems, and agree on behalf of myself and my heirs and assigns, that this State ORP Incidental Death Benefit payment so made shall be a complete discharge of the claim or claims, and shall constitute a release of the Retirement Systems from any further obligations on account of the State ORP Incidental Death Benefit. I reserve the right to change the designated beneficiary(ies) by a written designation filed with the SC Retirement Systems in accordance with its rules and regulations.

4. PAYMENT: The SC Retirement Systems shall be fully discharged of liability for all amounts paid to the beneficiary(ies), and shall have no other obligation as to the application of such amounts. In any dealing with a beneficiary(ies), including but not limited to any consent, release, or waiver of interest, the SC Retirement Systems shall be fully protected against the claim or claims of every other person.