



**STATE EMPLOYEE HEALTH PLAN (SEHP)  
HEALTH CARE SELECTION FORM**

**PLEASE READ CAREFULLY**

The **Tax Equity and Fiscal Responsibility Act** of 1982 and Public Law 99-272 (COBRA) requires those active employees and their spouses, age 65 and older to select either Medicare or the group's private health coverage as primary.

**THIS TOP PORTION MUST BE COMPLETED IN ALL INSTANCES**

	AGENCY / GROUP	NAME (LAST, FIRST MI)	EMPLOYEE ID# / SSN	GENDER	DATE OF BIRTH MM/DD/YY
MEMBER				<input type="checkbox"/> M <input type="checkbox"/> F	
SPOUSE (IF COVERED)				<input type="checkbox"/> M <input type="checkbox"/> F	

**1) To be completed by the Member:**

I select the following coverage as primary:

- State Employee Health Plan  
or
- Medicare (Note: If Medicare is selected as primary, you will be removed from the State Employee Health Plan. To do so, please complete a Change Form. To obtain this form, please see your Human Resources Department.)

<b>Member's Signature</b>	<b>Date</b>
---------------------------	-------------

**2) To be completed by the Member's Spouse:**

I select the following coverage as primary:

- State Employee Health Plan  
or
- Medicare (Note: If you select Medicare as primary, you will be removed from the State Employee Health Plan. To do so, please complete a Change Form. To obtain this form, the member must visit their Human Resources Department.)

<b>Spouse's Signature</b>	<b>Date</b>
---------------------------	-------------

**Note:** If you select the State Employee Health Plan, the coverage will be the same as if you were an active employee under age 65 in the group.