SCEIS Information Form

For New Hires, Promotions, Demotions, and Reassignments:

Employee Name _____

FTE / TEMP _____

SCEIS Number _____

Work Hours _____

Work Schedule _____

Work Phone Number _____

Is This a Supervisory Position **Yes** ☐ No ☐

Highest Level of Education _____

(If not included on application, indicate degree or highest year of schooling completed and Institute/Location)

Select all that apply

☐ Employee needs ECC (finance/procurement)
☐ Employee needs SRM (finance/procurement)
☐ HMMS Time Entry
☐ SCEIS Central Time Entry
☐ Callback Pay

FOR NEW HIRES ONLY:

☐ Single
☐ Married

Military Status: (Selection Cannot Be Changed)

☐ Federal Fiscal Year (October 1 - September 30)
☐ Calendar Year (January 1 - December 31)
☐ Non Military

Veteran Status:

☐ Non Veteran
☐ Veteran (Please Provide Copy of DD214)

Retirement Election: SCRS ☐ TERI ☐ Non-Election ☐ RSCR ☐

SORP ☐ (Select SORP vendor) _____

Have you ever been employed with SCDOT or another State Agency in SC? Yes ☐ No ☐

- If yes, please provide SCEIS employee number _____
- If yes, please provide most recent year of separation _____

Have you retired from SCDOT or another State Agency in SC? Were you employed with SCDOT prior to September 2011? Yes ☐ No ☐

Are you an active member of the South Carolina National Guard? Yes ☐ No ☐

Enrollee Data

SSN: [ ]

* Status: [Full Time Perm ▾]

*Name Last: [ ] *First: [ ] M.I.: [ ] Suffix: [ ]

*Birth Date: [ ] - [ ] - [ ] (mm-dd-yyyy)

* Email: [ ]

*Salary: [ ] *Date of Hire: [ ] - [ ] - [ ] (mm-dd-yyyy)

Coverage Effective Date: [ ] - [ ] - [ ] (mm-dd-yyyy)

Calculated if left blank.

* Indicates fields required for data entry on other screens.

ACKNOWLEDGEMENT OF RECEIPT

Of

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS

EMPLOYEE'S NAME (PRINT): _____

EMPLOYEE'S SCEIS NUMBER: _____

EMPLOYEE'S SIGNATURE:_____

DATE: _____

November 2014

ACKNOWLEDGEMENT OF RECEIPT

FOR

NOTICE OF HIPPA SPECIAL ENROLLMENT RIGHTS AND PRE-EXISTING CONDITION EXCLUSIONS

EMPLOYEES NAME: _____

EMPLOYEE NUMBER: _____

EMPLOYEE SIGNATURE: _____

DATE: _____

ACTIVE NOTICE OF ELECTION (NOE)

SOUTH CAROLINA PUBLIC EMPLOYEE BENEFIT AUTHORITY

A

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.

ACTION

Select One	Type of Change	BA Use Only
☐ New Hire/Election	☐ Enrollment	Effective Date: _____ ☐ Permanent P/T EE *(20 hrs.)*
☐ Transfer	Other (*specify*) _____	Group ID #: _____ Pay periods per year: _____
☐ Change	Date of Change Event _____	Group Name: _____

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

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)
						$	

COVERAGE

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

PLAN	COVERAGE LEVEL
☐ Refuse	☐ Employee
☐ Standard	☐ Employee/Spouse
☐ Savings	☐ Employee/Child(ren)
☐ TRICARE Supplement	☐ 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

MONEYPLUS ELECTIONS

27. MONEYPLUS ELECTIONS **MoneyPlus Pretax Premiums** ☐ Refuse ☐ Enroll

If you enroll in the Savings Plan, you cannot enroll in a Medical Spending Account (Section A), but can enroll in a Limited-use MSA (Section D). There is a $1.10 monthly administrative fee for Medical Spending, Dependent Care and Limited-use Medical Spending accounts.

A. MEDICAL SPENDING ACCOUNT
☐ New Enrollment ☐ Reenrollment ☐ Refuse

Receive reimbursement for eligible medical expenses incurred by you, your family members, or both. The maximum allowable contribution is $3,400 annually.

Plan year total amount: $ _____

B. DEPENDENT CARE SPENDING ACCOUNT **(for child/adult daycare)**
☐ New Enrollment ☐ Reenrollment ☐ Refuse

Tax filing status, please check one:
☐ Married, filing separately (Maximum - $3,750*) _____ Daycare costs increase/decrease
☐ Single, head of household (Maximum - $7,500*) _____ Dependent child turns 13
☐ Married, filing jointly (Maximum - $7,500*)

Plan year total amount: $ _____

**Contribution limit for highly compensated employees is $1,600. For 2026, the IRC defines highly compensated employees as those who earned $160,000 or more in calendar year 2025.*

C. HEALTH SAVINGS ACCOUNT
☐ New Enrollment ☐ Contribution Amount Change ☐ Refuse

Select which type of State Health Plan Savings Plan coverage you have:
☐ Individual (Maximum - $4,400)
☐ Family (Maximum - $8,750)
☐ Over 55 Catch-up (additional $1,000)

Plan year total amount:
$ _____

D. LIMITED-USE MEDICAL SPENDING ACCOUNT
☐ New Enrollment ☐ Reenrollment ☐ Refuse

Receive reimbursement for eligible dental and vision expenses incurred by you, your family members, or both. The maximum allowable contribution is $3,400 annually.

Plan year total amount: $ _____

Qualified Change Events (Check and date all that apply) for A & B:

_____ Marriage	_____ Spouse/dependent passed away	_____ Spouse ends unpaid leave	_____ Other
_____ Newborn	_____ Employee begins unpaid leave	_____ Spouse begins unpaid leave	
_____ Adoption	_____ Employee ends unpaid leave	_____ Job change from part-time to full-time	
_____ Divorce	_____ Ineligible dependent child	_____ Job change from full-time to part-time	

EMPLOYEE INITIALS _____ **DATE** _____

Social Security number: ______________ BIN: ____________ Last Name: ______________________ First Name: ______________________

MEDICARE

28. List yourself and any other persons to be covered who are eligible for Medicare Part A and/or Part B.

Name	Medicare #	Eligible due to	Effective Date	
			Part A (MM/DD/YYYY)	Part B (MM/DD/YYYY)
		☐ Age ☐ Disability ☐ Renal Disease		
		☐ Age ☐ Disability ☐ Renal Disease		

BENEFICIARIES

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

Basic Life/Opt Life (select one or both) ☐ Basic Life ☐ Optional Life

Primary/Contingent (select one) ☐ Primary ☐ Contingent

SSN ______ Last Name ______ First Name ______ Relationship ______ Date of Birth (MM/DD/YYYY) ______

Address ☐ Same as subscriber (Street, City, State, Zip) ______________________

Phone number ______________ Email address ______________

Basic Life/Opt Life (select one or both) ☐ Basic Life ☐ Optional Life

Primary/Contingent (select one) ☐ Primary ☐ Contingent

SSN ______ Last Name ______ First Name ______ Relationship ______ Date of Birth (MM/DD/YYYY) ______

Address ☐ Same as subscriber (Street, City, State, Zip) ______________________

Phone number ______________ Email address ______________

Basic Life/Opt Life (select one or both) ☐ Basic Life ☐ Optional Life

Primary/Contingent (select one) ☐ Primary ☐ Contingent

SSN ______ Last Name ______ First Name ______ Relationship ______ Date of Birth (MM/DD/YYYY) ______

Address ☐ Same as subscriber (Street, City, State, Zip) ______________________

Phone number ______________ Email address ______________

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 or 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

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 ______________

INSTRUCTIONS FOR COMPLETING THE ACTIVE NOTICE OF ELECTION (NOE)

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.

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. 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.

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 20: 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 21: 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 22: 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 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 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 23: DEPENDENT LIFE - SPOUSE: Before making a selection, refer to the detailed instructions provided by your employer. To select coverage, check Total Coverage Amount and enter the total 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 24: OPTIONAL LIFE: Before making a selection, refer to the detailed instructions provided by your employer. To select coverage, check Total Coverage Amount and enter the total 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 25: 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 26: VISION CARE: Before making a selection, refer to the plan description provided by your employer.

Block 27: MONEYPLUS ELECTIONS**:** To enroll in a **Medical Spending Account**, complete **Section A**. To enroll in a **Dependent Care Spending Account**, complete **Section B**. Complete **Section C** to enroll in or to change a **Health Savings Account**. (Additional forms will be required to establish your HSA.) If you would also like to enroll in a **Limited-used Medical Spending Account** for eligible dental and vision expenses, complete **Section D**.

Block 28. MEDICARE: List yourself and any other persons to be covered who are eligible for Part A and/or Part B of Medicare.

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 an employer covered by PEBA insurance, 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.

Block 31. CERTIFICATION AND AUTHORIZATION: Employees must initial and date the first page in the area provided. The second page of the 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 **PEBA Insurance Benefits at P.O. Box 11661 Columbia, SC 29211-1661.**

PEBA
SC Retirement Systems and State Health Plan

South Carolina Public Employee Benefit Authority
Serving those who serve South Carolina

Certification Regarding Tobacco or E-cigarette Use

Check the appropriate box, sign and return to S.C. PEBA, 202 Arbor Lake Drive, Columbia, SC 29223.

Subscriber name:_____ Subscriber BIN/SSN: _____

Non-tobacco or e-cigarette user

❑ I certify I am eligible for the non-tobacco-use premium by checking this box and returning this form to PEBA. By checking this box, I certify truth and understanding of the following:

- I certify all persons covered on my health insurance coverage through PEBA (including myself and any dependents) are not currently using, and have not used, any tobacco products or electronic cigarettes in any form (cigarettes, cigars, pipe, oral tobacco products, etc.) within the last six months.
- I certify if this information changes at any time in the future while I have health insurance coverage through PEBA, I will notify PEBA of such change within 31 days through completion and resubmission of this form.
- I certify this information is true and correct to the best of my knowledge.
- I understand if it is determined that I (or any of my covered dependents) have used tobacco products or electronic cigarettes within the last six months or if I (or any of my covered dependents) start using tobacco products or electronic cigarettes subsequent to the date of this certification without notifying PEBA, I will be subject to penalties including, but not limited to, payment of premium difference since last certification plus a 10% penalty and elimination of the user's out-of-pocket maximum for current year and subsequent year.
- I understand 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-use premium I have already paid.

❑ I certify I am eligible for the non-tobacco-use premium by checking this box and returning this form to PEBA. By checking this box, I certify truth and understanding of the following:

- I certify all covered individuals who use tobacco or electronic cigarettes have completed the State Health Plan's tobacco cessation program.
- I certify this information is true and correct to the best of my knowledge.
- I understand 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-use premium I have already paid.

Tobacco or e-cigarette user

❑ I acknowledge I will pay the tobacco-use premium by checking this box. I declare that one or more persons covered on my health insurance coverage through PEBA uses tobacco products or electronic cigarettes in some form or that I choose not to disclose my status as it relates to tobacco or e-cigarette use. I understand that by not making an election I am choosing to pay the tobacco-use premium. Do not send me this certification again unless upon request.

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. 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.

NAVIGATING YOUR BENEFITS

Supporting Documentation for Insurance Enrollments

Below is a list of acceptable documentation to prove the relationship of dependents you are adding to insurance coverage. Upload images of your documentation in MyBenefits or ask your employer to do so on your behalf. Any documentation in a language other than English must be completely translated into English and should be certified with a letter of accuracy from the translator.

If you do not have the required documentation, you might have to pay a fee to receive it from the government agency with the original. We encourage you to request your documentation as soon as possible, since this process could take several weeks, and many agencies increase fees for expedited delivery for the following documents.[1]

- Marriage license or birth certificate: www.cdc.gov/nchs/w2w.htm; or
- Birth certificate (for children born in South Carolina): www.dph.sc.gov/public/vital-records.

Legal spouse

Marriage license or Page 1 of your latest federal tax return, if filing jointly.

Former spouse

Photocopy of divorce decree ordering the subscriber to cover the former spouse.

Natural child

A copy of a long-form birth certificate[2] showing the subscriber as the parent.

Stepchild

A copy of the long-form birth certificate[1] showing the name of the natural parent, as well as proof that the natural parent and the subscriber are married (see Legal spouse requirement).

Adopted child

- A copy of the long-form birth certificate[1] showing the subscriber as the parent; or
- Court documentation verifying completed adoption; or
- A letter of placement from an adoption agency, an attorney or the S.C. Department of Social Services verifying the adoption is in progress.

Foster child

A court order or other legal document placing the child with the subscriber, who is a licensed foster parent.

Other children

For all other children for whom a subscriber has legal custody, a court order or other legal document granting custody of the child to the subscriber. Documentation must verify the subscriber has guardianship responsibility for the child, not just financial responsibility.

Incapacitated child

Incapacitated Child Certification form plus proof of relationship. See the appropriate child type (natural, step, adopted, foster or other) for acceptable proof of relationship.

[1]In some cases, you might not have the appropriate documentation before the enrollment deadline. If the deadline to enroll is nearing, submit the election of benefits without the documentation before the deadline, and then submit the documentation as soon as it is available.

[2]A short-form birth certificate does not include the parents' names and will not be accepted. The S.C. Department of Public Health issues long forms. Visit www.dph.sc.gov/public/vital-records for more information. If your child was born outside of South Carolina, go to www.cdc.gov/nchs/w2w.htm for a list of vital statistics agencies in other U.S. states and territories.

This document does not constitute a comprehensive or binding representation regarding the employee benefits offered by PEBA. The terms and conditions of insurance plans offered by PEBA are set out in the applicable plan documents and are subject to change. The language on this flyer does not create any contractual rights or entitlements for any person. PEBA complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 888.260.9430. 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 888.260.9430

PEBA SC Retirement Systems and State Health Plan

SCPEBA 112025| Expires 12312026
Data classification: public information

Form 1100
Revised 7/1/2023
Page 1

RETIREMENT PLAN ENROLLMENT

S.C. Public Employee Benefit Authority
Retirement Benefits
Attention: Enrollment
202 Arbor Lake Drive
Columbia, SC 29223

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 selected, complete item 17.)
- ☐ JSRS (Judge, Solicitor, Circuit Public Defender, or Administrative Law Court)

17. Select State ORP Service Provider

- ☐ Corebridge Financial ☐ TIAA
- ☐ Empower ☐ Voya

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 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 and/or my selected State ORP service provider 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 _____

Please contact PEBA's Customer Service with any questions at 803.737.6800 or 888.260.9430, or www.peba.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 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 were 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 service provider 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 PEBA 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 11/1/2017
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
202 Arbor Lake Drive
Columbia, SC 29223

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

*** YOUR BENEFICIARY DESIGNATIONS WILL NOT BE REVOKED UNDER SECTION 62-2-507 OF THE SOUTH CAROLINA CODE OF LAWS BY DIVORCE, ANNULMENT, OR ORDER TERMINATING MARITAL PROPERTY RIGHTS.**

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 PUBLIC EMPLOYEE BENEFIT AUTHORITY. THE SOUTH CAROLINA PUBLIC EMPLOYEE BENEFIT AUTHORITY 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 SOUTH CAROLINA PUBLIC EMPLOYEE BENEFIT AUTHORITY (PEBA). 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 PEBA 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 PEBA 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 PEBA 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 PEBA, 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 PEBA 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, PEBA 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 PEBA in accordance with its rules and regulations.
4. **PAYMENT:** PEBA 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, PEBA 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.

Form 1106
Revised 7/1/2025

STATE ORP ACTIVE INCIDENTAL DEATH BENEFIT BENEFICIARY DESIGNATION

SC Public Employee Benefit Authority
Attention: Enrollment
202 Arbor Lake Drive
Columbia, SC 29223

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 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
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

*** YOUR BENEFICIARY DESIGNATIONS WILL NOT BE REVOKED UNDER SECTION 62-2-507 OF THE SOUTH CAROLINA CODE OF LAWS BY DIVORCE, ANNULMENT, OR ORDER TERMINATING MARITAL PROPERTY RIGHTS.**

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 OR ALTERNATE PAYEE'S SIGNATURE _____ DATE _____
(Certified copy of legal authorization required with signature other than applicant's)

WITNESS _____ DATE _____
(Required only when signed by a mark)

STATE OF _____ COUNTY OF _____

ACKNOWLEDGED BEFORE ME THIS DATE _____ NOTARY NAME _____
MM/DD/YYYY (Please print)

MY COMMISSION EXPIRES _____ NOTARY SIGNATURE _____

NOTARY BUSINESS PHONE _____

Please contact PEBA's Customer Contact Center with any questions at 803.737.6800 or 888.260.9430, or www.peba.sc.gov.

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 PUBLIC EMPLOYEE BENEFIT AUTHORITY. THE SOUTH CAROLINA PUBLIC EMPLOYEE BENEFIT AUTHORITY RESERVES THE RIGHT TO REVISE THE CONTENT OF THIS DOCUMENT.

INSTRUCTIONS

ACTIVE STATE ORP PARTICIPANTS SHOULD USE THIS FORM FOR INCIDENTAL DEATH BENEFIT (IDB) BENEFICIARY DESIGNATIONS. THIS FORM MUST BE COMPLETED IN ITS ENTIRETY EACH TIME A BENEFICIARY DESIGNATION IS MADE OR CHANGED. IDB BENEFICIARIES MAY ALSO BE SECURELY DESIGNATED OR UPDATED ONLINE THROUGH MEMBER ACCESS.

NOTE: Beneficiaries designated to received contributions and earnings accumulated in your STATE ORP RETIREMENT ACCOUNT, must be named and updated directly with your chosen service provider.

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 Public Employee Benefit Authority (PEBA) 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 PEBA, 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 PEBA 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 PEBA in accordance with its rules and regulations.

4. PAYMENT: PEBA 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, PEBA shall be fully protected against the claim or claims of every other person.

Form 1103
Revised 11/1/2017
Page 1
Print or type in black ink

BENEFICIARY/TRUSTEE DESIGNATION FORM

SC Public Employee Benefit Authority
202 Arbor Lake Drive
Columbia, SC 29223

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

Use for designation of 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:

1. I certify that I desire to designate my Trust to receive my Retirement Systems benefits. The name of my Trust (already in existence) is _____ Dated _____

I certify that the following person will serve as the Trustee of my Trust after my death: _____

Address of Trustee(s) _____

☐ My Trust Beneficiary(ies) is a live person. I understand that in order for a survivor benefit to be paid, I or my Trustee(s) will be required to provide the excerpt of the Trust document reflecting all of the Trust beneficiaries. Otherwise, only a lump sum benefit will be paid.

☐ My Trust Beneficiary(ies) is not a live person. I understand that only a lump sum benefit will be paid.

2. Name of Beneficiary (ONE PERSON) (without a trust)	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 survivor benefits:

1. I certify that I desire to designate my Trust to receive my Retirement Systems benefits. The name of my Trust (already in existence) is _____ Dated _____

I certify that the following person will serve as the Trustee of my Trust after my death: _____

Address of Trustee(s) _____

☐ My Trust Beneficiary(ies) is a live person. I understand that in order for a survivor benefit to be paid, I or my Trustee(s) will be required to provide the excerpt of the Trust document reflecting all of the Trust beneficiaries. Otherwise, only a lump sum benefit will be paid.

☐ My Trust Beneficiary(ies) is not a live person. I understand that only a lump sum benefit will be paid.

2. Name of Beneficiary (ONE PERSON) (without a trust)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship

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

1. I certify that I desire to designate my Trust to receive my Retirement Systems benefits. The name of my Trust (already in existence) is _____ Dated _____

I certify that the following person will serve as the Trustee of my Trust after my death: _____

Address of Trustee(s) _____

☐ My Trust Beneficiary(ies) is a live person. I understand that in order for a survivor benefit to be paid, I or my Trustee(s) will be required to provide the excerpt of the Trust document reflecting all of the Trust beneficiaries. Otherwise, only a lump sum benefit will be paid.

☐ My Trust Beneficiary(ies) is not a live person. I understand that only a lump sum benefit will be paid.

2. Name of Beneficiary (ONE PERSON) (without a trust)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship

*** YOUR BENEFICIARY DESIGNATIONS WILL NOT BE REVOKED UNDER SECTION 62-2-507 OF THE SOUTH CAROLINA CODE OF LAWS BY DIVORCE, ANNULMENT, OR ORDER TERMINATING MARITAL PROPERTY RIGHTS.**

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 _____ (Do not print) Witness _____ (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 PUBLIC EMPLOYEE BENEFIT AUTHORITY. THE SOUTH CAROLINA PUBLIC EMPLOYEE BENEFIT AUTHORITY RESERVES THE RIGHT TO REVISE THE CONTENT OF THIS DOCUMENT.

Please contact PEBA's Customer Contact Center with any questions at 803.737.6800 or 888.260.9430, or www.peba.sc.gov.

INSTRUCTIONS

USE THIS FORM 1103 FOR ANY BENEFICIARY DESIGNATIONS THAT REQUIRE A TRUSTEE APPOINTMENT. ANY ADDITIONAL BENEFICIARY(IES), NOT REQUIRING A TRUSTEE APPOINTMENT MUST ALSO BE INCLUDED ON THIS FORM 1103.
CAUTION: IF YOUR BENEFICIARY(IES) DOES NOT REQUIRE A TRUSTEE APPOINTMENT, DO NOT USE THIS FORM 1103. THE CORRECT FORM TO USE IS THE FORM 1102.
NOTE: THIS FORM MUST BE COMPLETED IN ITS ENTIRETY EACH TIME IT IS SUBMITTED. AN ACKNOWLEDGMENT LETTER WILL BE SENT TO THE MEMBER EACH TIME A FORM IS RECEIVED BY THE SOUTH CAROLINA PUBLIC EMPLOYEE BENEFIT AUTHORITY (PEBA).
Check the appropriate boxes in the upper right corner. If you are a member of more than one system, complete a FORM 1103 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 1103 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

Please indicate the name of trust (must be an already established trust), date of trust, as well as the name and address of the trustee. Then check the appropriate block indicating whether or not the trust beneficiary is a live person as opposed to an artificial entity. **PLEASE NOTE: IF THE TRUST BENEFICIARY IS NOT A LIVE PERSON, THEN ONLY A LUMP SUM REFUND WILL BE PAYABLE!** If you wish to designate a beneficiary that will not be covered by the trust, then complete the information requested in block 2 of section II-A. If additional space is needed to designate more than two non-trust beneficiaries, complete and attach another FORM 1103 and indicate on the form how many pages are being submitted. That information will assist PEBA in determining the total number of forms submitted in the event the forms are separated during processing. Information concerning the SSN, sex, date of birth and relationship are applicable to the beneficiary and the member, NOT the trustee and the member.
NOTE: SURVIVOR BENEFITS WILL NOT BE PAID TO AN ESTATE OR AN ARTIFICIAL BEING - 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 the 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 wish to make a trust designation for your contingent beneficiary(ies), please complete section II-B (1) using the same instructions as for II-A (1) above. If you wish to name a contingent benneficiary not covered by a trust, complete section II-b (2). If you do not wish to designate any contingent beneficiaries, write "NONE" in Section II-B on the reverse (Page 1) of this form.

SECTION III: INCIDENTAL DEATH BENEFIT

You may name different beneficiaries for the Incidental Death Benefit (a benefit equal to your annual salary), which is 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 PEBA for Incidentatl Death Benefit information. If you wish to make a trust designation for your Incidental Death Benefit, please complete section III (1) using the same instructions as for II-A (1) above. If you wish to name an Incidental Death Benefit beneficiary not covered by a trust,complete section III (2). If you do not have Incidental Death Benefit coverage, write "N/A" in Section III on the reverse (Page 1) of this form.

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:** Previous beneficiary and trustee designations are hereby revoked.
3. **AUTHORIZATION:** I hereby authorize PEBA 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 trustee(s) and beneficiary(ies) designated on the front of this form (Page 1) in accordance with the provisions of the PEBA, and agree on behalf of myself and my heirs and assigns, that any payment so made shall be a complete discharge of the claims or claims, and shall constitute a release of the PEBA from any further obligations on account of the benefit or benefits. In the event PEBA receives satisfactory proof that the trust(s) has been revoked or is otherwise not in effect at the time of my death, any refund of contributions or any survivor benefits shall be paid directly to the beneficiary(ies) designated on this form.
   In the event my named primary beneficiary(ies) predeceases me and if a contingent beneficiary(ies) designation is on file, PEBA 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 PEBA in accordance with its rules and regulations.
4. **PAYMENT:** PEBA shall be fully discharged of liability for all amounts paid to trustee(s) or beneficiary(ies), and shall have no other obligation as to the application of such amounts. In dealing with a trustee(s), including but not limited to any consent, release, or waiver of interest, the PEBA shall be fully protected against the claim or claims of every other person. It shall not be charged with notice of a change of trustee(s), unless **WRITTEN** evidence of the change is received by the PEBA before or at the time a trustee(s) becomes entitled to payment. PEBA shall not be bound by the terms of any trust or any trust agreement or instrument, and PEBA shall not be liable for the application of the proceeds of retirement benefits by trustee(s) or any other person.
5. **MULTIPLE TRUST BENEFICIARIES:** Survivor benefits payable to the trustee(s) on the behalf of two or more beneficiaries of the trust shall be calculated based on the average age of the beneficiaries on Page 1 of this form. Payments will be equally divided among surviving beneficiaries at the member's death.

Please share the following message with your employees to let them know about this new enrollment option through the South Carolina Deferred Compensation Program (Deferred Comp).

Online enrollment is now available.

Eligible employees now have the option to enroll online in Deferred Comp's 401(k) and/or 457(b) plans so you can start your savings journey quickly and easily. Learn more about Deferred Comp online.

To enroll online, visit **southcarolinadcp.com**.

- Click on *REGISTER/ENROLL* under *Participant Login*.
  To visit the site from a mobile phone or tablet, you must download the Empower app. In the mobile app, select *Register now* to begin the enrollment process.

- Select the *I have a plan enrollment code* tab.

- If you want to enroll in the 401(k) Plan:
  - Enter the Group ID/Plan number: **98955-01**
  - Enter the Plan Enrollment Code: **yYAnZF4d** *(expires February 1, 2026)*

- If you want to enroll in the 457(b) Plan:
  - Enter the Group ID/Plan number: **98955-02**
  - Enter the Plan Enrollment Code: **bs8agaCz** *(expires February 1, 2026)*

- Follow the prompts to enroll.
  - You have the option to enroll in either plan or both during the enrollment process.
  - You can elect to contribute a flat dollar amount per paycheck or a percentage of pay. The minimum contribution amount for each plan is $10.
  - You can choose to contribute before tax, Roth (after-tax) or a combination of both.
  - Your enrollment is complete after you select, *I Agree, Enroll now*.
  - If you enroll in both plans, you will be required to complete deferral and investment elections separately, but the system will prompt you to do so.

- Do you have questions about the differences between the 401(k) and 457(b) plans? Learn more online.

Questions? Contact Empower's Participant Service representatives at **877.457.6263**. Representatives are available weekdays between 8 a.m. and 10 p.m., and Saturdays between 9 a.m. and 5:30 p.m. Eastern Standard Time.

I'm also happy to assist you with enrolling online and learning how Deferred Comp can help you prepare for your future retirement. You can easily set up a meeting with me by visiting https://richard-loy.empowermytime.com/

Sincerely,
Richard R. Loy
Retirement Plan Advisor
303.386.0799

Investing involves risk, including possible loss of principal.

Securities, when presented, are offered and/or distributed by Empower Financial Services, Inc., Member FINRA/SIPC. EFSI is an affiliate of Empower Retirement, LLC; Empower Funds, Inc.; and registered investment adviser Empower Advisory Group, LLC. This material is for informational purposes only and is not intended to provide investment, legal, or tax recommendations or advice. "EMPOWER" and all associated logos and product names are trademarks of Empower Annuity Insurance Company of America.

©2024 Empower Annuity Insurance Company of America. All rights reserved. RO3355925-0124