

APPLYING FOR INSURANCE
under the
Traditional or Portable Benefit Packages



State Universities Retirement System of Illinois
Information and Applications

UNIVERSITY EMPLOYEES ONLY



State of Illinois Insurance

Pages 3–12 pertain to members of the State Group Health Plan. To be eligible for this plan, you must have at least 5 years of service credit with a state university or an agency of the State of Illinois (for example, Dept. of Corrections). Note: Community Colleges are not state agencies.

This image appears on each STATE form.

MEDICARE INFORMATION

Members and/or dependents under any form of State health insurance who turn 65 OR retire on or after July 1, 1992, and are eligible for premium-free Part A of Medicare, will have their State medical benefits reduced if they do not enroll in Part B of Medicare. To avoid additional out-of-pocket claim costs, we strongly suggest you enroll in and retain Medicare Part A and Part B for yourself and eligible dependents. Please submit a copy of your Medicare card showing dates of coverage for yourself and each eligible dependent. If you have received notice from Social Security that you and/or your dependents are not eligible for premium-free Medicare Part A, send a copy of that notice to SURS along with your retirement application. If enrolled, Medicare will become your primary insurance at retirement. Your State insurance will act as a supplement to Medicare.

If you have any questions regarding Medicare, contact the Medicare COB Unit at 1-800-442-1300 or 217-782-7007.

State of Illinois

Enrollment Instructions



Participation Election Form (p. 5)

If you have a minimum of 5 years of qualified service, but less than 20 years, and were not employed on July 7, 1997, you **MUST** complete the Participation Election Form.

State Employees Group Insurance Enrollment Form (p. 7)

Complete this form only if you are not currently enrolled in the State of Illinois Group Insurance Plan, or wish to make changes to your current coverage. **ALL** changes will take effect when annuity payments begin. If you are not currently enrolled and would like information about the plan, please contact SURS.

Section A – Complete your personal biographical data.

Section B – Indicate elections for your health and dental coverage. If you elect an HMO or POS medical plan, you **MUST** select a primary care physician and list their primary care physician number. If you are enrolled with Medicare, you **MUST** submit a copy of your Medicare card with your enrollment worksheet. If you are 65 or over, you **MUST** submit a copy of your Medicare card or letter of ineligibility.

Section C – Complete this section for any dependent(s) you wish to enroll with health and dental coverage. All dependents are enrolled with the same carriers as the member. If you elected an HMO or POS medical plan, your dependent(s) must select a primary care physician and list their primary care physician number. If your dependent(s) are age 65 or over, you **MUST** submit a copy of their Medicare card or letter of ineligibility with your enrollment worksheet.

Section D – Complete this section only if you are enrolling your spouse with insurance coverage.

Section E – To determine any pre-existing limitations for your health coverage, we need to know if you were covered by other Group Insurance prior to your enrollment with the State insurance plan. If you were covered under another Group Insurance plan (including Medicare) within 63 days of enrolling under the State plan, you must obtain a Certificate of Creditable Coverage from your current carrier to limit the pre-existing time limit for your health benefits. Submit this certificate along with your enrollment worksheet.

SIGN and **DATE** the enrollment worksheet.

State Employees Group Life Insurance Form (p. 9)

Section A – Complete your personal biographical data.

Section B – If you are currently enrolled in life insurance and wish to terminate any or all coverage, complete this section.

Section C – If you are an immediate annuitant (your termination date and retirement date are within one year of each other) and wish to purchase life insurance, choose from the options listed.

SIGN and **DATE** the form.

State Opt Out Election Certificate (p. 11)

If you have over 20 years of eligible service under the State of Illinois Group Insurance Plan and have comprehensive medical coverage elsewhere, you can elect to terminate your State of Illinois Group Insurance Coverage. Members are required to have the state-paid basic life coverage and may elect voluntary optional life coverage.

Members who wish to opt out of health, dental, and vision coverage must complete an Opt Out Election Certificate and submit proof of other comprehensive major medical indemnity or managed care health coverage from a source other than the Department of Central Management Services. Proof of other insurance includes an insurance card (submit a photocopy of the front and back side of the card) or enrollment verification that indicates coverage is, or will be, in effect on or before the termination date from the Program.



STATE UNIVERSITIES RETIREMENT SYSTEM
 1901 Fox Drive
 Champaign, IL 61820
 Telephone 1 (800) 275-7877 or (217) 378-8800 (C-U Area)



STATE OF ILLINOIS GROUP INSURANCE PROGRAM PARTICIPATION ELECTION FORM

NOTICE: If you have less than 20 years of qualified service and were NOT employed on July 7, 1997, this form must be completed and returned to our office.

Members who have at least 5 years of qualified service:

Are eligible to participate in the State Insurance Program at the time of their retirement.

Members retiring on or after January 1, 1998, with less than 20 years of qualified service, who were not employed on July 7, 1997:

Will be required to share in the cost of their health insurance coverage. For each year of qualified service, the State will contribute 5% toward the cost of the member's insurance. Premiums for dental and dependent coverage are additional. All premiums will be deducted from your annuity payment.

For members with less than 20 years of qualified service:

Participation in the State health/dental insurance program is optional. Members not electing to enroll with health/dental coverage will still be eligible for and enrolled in the life insurance program.

Members electing not to participate in the State health/dental insurance program are eligible to participate at a later date by enrolling during the annual Benefits Choice Period or during a qualified change in family status.

Check one box only

- YES, I elect to participate in the State insurance program.
 I understand I will be required to share in the cost of my health/dental insurance benefits. *For current health/dental rates, contact SURS.*
- NO, I do not elect to participate in the State health/dental insurance program at this time.
 I understand I will be enrolled with life insurance coverage only.

Signature	Date	Social Security No.	Retirement Date

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STATE EMPLOYEES GROUP INSURANCE ENROLLMENT FORM

SECTION A - Member Information (print or type)

Name (first, mi, last)	Social Security No.	Marital Status: <input type="checkbox"/> Never married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced
Home Address (physical location, needed due to HIPAA Act)		Date of Birth
Mailing Address (can be a P.O. Box #)		
Illinois Resident County		Daytime Phone (include area code)

SECTION B - Member Health and Dental Insurance

Health Insurance (check one)	<input type="checkbox"/> Quality Care Health Plan <input type="checkbox"/> HMO Name _____ Primary Care Physician # _____ (required if selecting an HMO)
Dental Insurance (check one)	<input type="checkbox"/> Quality Care Dental Plan <input type="checkbox"/> I elect to not enroll in the Quality Care Dental Plan at this time. I understand that I can only enroll in the plan during Benefits Choice Period.
Are you enrolled with Medicare? <input type="checkbox"/> No <input type="checkbox"/> Yes - If Yes, you must enclose a copy of your Medicare card.	

SECTION C - Dependent Coverage (complete only if you wish to cover dependent(s) with insurance coverage)

1	Name (first, mi, last)		Social Security #	
	Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Child under age 18 <input type="checkbox"/> Handicapped child <input type="checkbox"/> Full-time student age 19 to 24 (documentation required) <input type="checkbox"/> Student leave of absence <input type="checkbox"/> Student military extension <input type="checkbox"/> IRS sponsored adult child <input type="checkbox"/> Non-IRS sponsored adult child <input type="checkbox"/> IRS veteran adult child <input type="checkbox"/> Non-IRS veteran adult child		Date of Birth	
	Is dependent enrolled in Medicare? <input type="checkbox"/> No <input type="checkbox"/> Yes - If Yes, you must enclose a copy of their Medicare card.		Primary Care Physician #	
	Name (first, mi, last)		Social Security #	
2	Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Child under age 18 <input type="checkbox"/> Handicapped child <input type="checkbox"/> Full-time student age 19 to 24 (documentation required) <input type="checkbox"/> Student leave of absence <input type="checkbox"/> Student military extension <input type="checkbox"/> IRS sponsored adult child <input type="checkbox"/> Non-IRS sponsored adult child <input type="checkbox"/> IRS veteran adult child <input type="checkbox"/> Non-IRS veteran adult child		Date of Birth	
	Is dependent enrolled in Medicare? <input type="checkbox"/> No <input type="checkbox"/> Yes - If Yes, you must enclose a copy of their Medicare card.		Primary Care Physician #	
	Name (first, mi, last)		Social Security #	
	Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Child under age 18 <input type="checkbox"/> Handicapped child <input type="checkbox"/> Full-time student age 19 to 24 (documentation required) <input type="checkbox"/> Student leave of absence <input type="checkbox"/> Student military extension <input type="checkbox"/> IRS sponsored adult child <input type="checkbox"/> Non-IRS sponsored adult child <input type="checkbox"/> IRS veteran adult child <input type="checkbox"/> Non-IRS veteran adult child		Date of Birth	
Is dependent enrolled in Medicare? <input type="checkbox"/> No <input type="checkbox"/> Yes - If Yes, you must enclose a copy of their Medicare card.		Primary Care Physician #		

SECTION D - Spouse Retirement Information (complete only if you are enrolling your spouse with insurance coverage)

Is your spouse receiving retirement benefits? <input type="checkbox"/> No <input type="checkbox"/> Yes, spouse retirement date was _____
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SECTION E - Other Group Health Insurance

Have you or any of your dependents listed in Section C been covered by other group health insurance (including Medicare) within the last 63 days (NOT including the State of Illinois insurance)? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, enclose Certificate of Creditable Coverage from your current carrier or a copy of your or your dependent's Medicare card.) Will this coverage remain in effect after your enrollment with State of Illinois insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes, name of company is _____ Date coverage began _____
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I certify enrollment for the coverage indicated above. I authorize prevailing premiums to be deducted from my annuity for the coverage elected. I agree to abide by all appropriate rules and will furnish any additional information requested. All statements and answers contained herein are complete and true. I understand that failure to complete this form in its entirety may delay my insurance coverage.

Signature	Date
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STATE EMPLOYEES GROUP LIFE INSURANCE FORM

YOU CAN ONLY COMPLETE THIS FORM IF YOU ARE AN IMMEDIATE ANNUITANT (your termination date and retirement date are within one year of each other). IF YOU ARE A DEFERRED ANNUITANT (your termination date and retirement date are more than one year apart), YOU ARE NOT ENTITLED TO PURCHASE LIFE INSURANCE. YOU WILL BE ENROLLED IN STATE PAID BASIC ONLY.

SECTION A – Member Information (print or type)

Name (Last, First, Middle Initial)	Social Security No.
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SECTION B – Termination of Life Insurance

<input type="checkbox"/> I currently purchase additional life insurance and wish to terminate all or part of that coverage. <input type="checkbox"/> Optional Life # _____ units <input type="checkbox"/> Spouse Life <input type="checkbox"/> Child Life <input type="checkbox"/> AD&D Basic <input type="checkbox"/> AD&D Combined

SECTION C – Optional Life Insurance

A statement of health must be completed and returned to the state life insurance company for underwriting approval for the purchase of all life insurance except accidental death and dismemberment.

<input type="checkbox"/> I wish to purchase Accidental Death & Dismemberment insurance. <input type="checkbox"/> Basic Only <input type="checkbox"/> Combined (must have Optional Life insurance also)
<input type="checkbox"/> I wish to purchase \$10,000 Child Life insurance.
<u>Ages 18-59:</u> <input type="checkbox"/> I wish to purchase Optional Life insurance. How many units do you wish to purchase? <input type="checkbox"/> 1 x basic <input type="checkbox"/> 2 x basic <input type="checkbox"/> 3 x basic <input type="checkbox"/> 4 x basic <input type="checkbox"/> 5 x basic <input type="checkbox"/> 6 x basic <input type="checkbox"/> 7 x basic <input type="checkbox"/> 8 x basic <input type="checkbox"/> I wish to purchase \$10,000 Spouse Life insurance.
<u>Age 60 and older:</u> <input type="checkbox"/> I wish to purchase Optional Life insurance. <input type="checkbox"/> 1 x basic <input type="checkbox"/> 2 x basic <input type="checkbox"/> 3 x basic <input type="checkbox"/> 4 x basic <input type="checkbox"/> I wish to purchase \$5,000 Spouse Life insurance.

I certify enrollment for the coverage indicated above. I authorize prevailing premiums to be deducted from my annuity for the coverage elected. I agree to abide by all appropriate rules and will furnish any additional information requested. All statements and answers contained herein are complete and true. I understand that failure to complete the form in its entirety may result in a delay of my insurance coverage.

Signature	Date
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STATE OPT OUT ELECTION CERTIFICATE

In accordance with Public Act 92-0600, State of Illinois full-time employees, retirees/annuitants and survivors may elect to not participate in the health, dental, and vision coverage of the State of Illinois Group Insurance Program. Enrolled dependents of individuals electing to opt out will be terminated on the same date as the Member.

Name (last, first, initial)	Social Security No.
Daytime Telephone No.	Requested Effective Date of Opt Out

I fully understand and certify the following:

1. The election to opt out of the Program is entirely voluntary. If I elect to opt out, any dependent coverage will also be terminated. The State of Illinois is not responsible for any expenses incurred, for myself or my dependents, on or after my termination date. Furthermore, my covered dependents and I are not eligible for COBRA continuation coverage.
2. I must complete the Opt Out Election Certificate and furnish proof of enrollment in another health benefit plan, either comprehensive major medical or comprehensive managed care, from a source other than the Illinois Department of Central Management Services (Department) including the Local Government Health Plan, Teachers' Retirement Insurance Program, or College Insurance Program before my coverage will be terminated. My Program coverage will not be terminated until other eligible coverage is in effect, appropriate documentation has been submitted, and such documentation has been approved by the Department. The effective date of opt out is at the discretion of the Department and must comply with Program requirements regarding opt out.
3. I may opt out of the Program only during the Special Open Enrollment period (September 1–30, 2002), annual Benefit Choice period, or within 60 days of an eligible Qualifying Change in Status.
4. If my spouse is a Member of any plan administered by the Department including the State of Illinois Group Insurance Program, Local Government Health Plan, Teachers' Retirement Insurance Program or College Insurance Program, I may not enroll as a dependent of my spouse in that plan.
5. If I elect to opt out of the Program, I will continue to be enrolled in the state-paid basic life insurance plan. I understand I am eligible to participate in the optional life insurance plan but I am not eligible for the Flexible Spending Account (FSA) Program or the Qualified Transportation Benefit (QTB) Program.
6. At a later date, if I wish to re-enroll in one of the health plans administered by the Department, I understand pre-existing condition limitations may apply if I am unable to provide a Certificate of Creditable Coverage with no break in coverage of more than 63-days from my previous insurance carrier.
7. To the best of my knowledge and belief, the opt out documentation furnished to substantiate coverage in another health benefit plan is accurate and the policy is currently (or will be, prior to my termination) in force.

Member Signature	Date
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GIR/P Use Only	Proof of comprehensive coverage attached? Check the appropriate Opt Out eligibility period: <input type="checkbox"/> Special Open Enrollment (Sept. 1-30, 2002) <input type="checkbox"/> Benefit Choice <input type="checkbox"/> Qualifying Change in Status; Reason Code: _____ Group Insurance Rep. Signature & Date _____ Telephone # _____ Agency Name _____ Organizational Processing Code _____
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CMS Use Only	Coverage documentation submitted: <input type="checkbox"/> Approved <input type="checkbox"/> Denied <input type="checkbox"/> Pending Effective date of termination: _____ Benefits Management Division Signature _____ Date _____ Agency Name _____ Organizational Processing Code _____ GID Membership Unit process date _____ Code _____ Initials _____
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COMMUNITY COLLEGE EMPLOYEES ONLY

College Insurance Plan

Pages 13–18 pertain to members interested in the College Insurance Plan (CIP). To be eligible for the CIP, you must have been a full-time employee of any SURS–participating Community College for any period and be eligible for benefits. Note: City Colleges of Chicago do not participate in the CIP. SURS determines eligibility based on documentation from each employer. Please contact your school if you are unsure of your eligibility.

MEDICARE INFORMATION

Members and/or dependents under any form of CIP health insurance who turn 65 OR retire on or after July 1, 1992, and are eligible for premium–free Part A of Medicare, will have their CIP medical benefits reduced if they do not enroll in Part B of Medicare. To avoid additional out–of–pocket claim costs, we strongly suggest you enroll in and retain Medicare Part A and Part B for yourself and eligible dependents. Please submit a copy of your Medicare card showing dates of coverage for yourself and each eligible dependent. If you have received notice from Social Security that you and/or your dependents are not eligible for premium–free Medicare Part A, send a copy of that notice to SURS along with your retirement application. If enrolled, Medicare will become your primary insurance at retirement. Your CIP Insurance will act as a supplement to Medicare.

If you have any questions regarding Medicare, contact the Medicare COB Unit at 1-800-442-1300 or 217-782-7007.

CIP - Instruction Sheet For Benefit Recipient Group Insurance Form

Complete this form and mail to:
State Universities Retirement System, P.O. Box 2710, Champaign, IL 61825-2710

This form is used for initial enrollment into the College Insurance Program (CIP) and to make changes during the annual Benefit Choice Period. For Benefit Choice Period changes, you need only complete the sections that have changes. If you are adding a dependent you will need to complete the Dependent Beneficiary Group Insurance Form. Be sure to provide your and your dependent's complete name and Social Security Number (SSN). If you are enrolling in CIP for the first time during the annual Benefit Choice Period, check the Initial Enrollment box and the Benefit Choice box. For initial enrollment in CIP outside the Benefit Choice Period, check the Initial Enrollment box and complete the entire form.

SECTION I – Personal Information (please type or print clearly)

Effective date of enrollment: Enter the date coverage is effective (see the Benefits Handbook for coverage effective dates). Enrollments requested during the Benefit Choice Period will be effective July 1. **Marital Status:** S=Single, M=Married
Birthdate: Enter two-digit month, two-digit day and four-digit year. Example: 07/28/1945 **Sex:** M=Male, F=Female

SECTION II – Medicare Status

Medicare Status – Check the box that correctly reflects your Medicare status.
Medicare Box 1 – You are under 65 years of age and ineligible for Medicare due to age.
Medicare Box 2, 4 or 5 – Provide specific Part A, Part B and/or Part D dates and indicate whether Part A of Medicare is free. A copy of your Medicare card(s) must accompany this form.
Medicare Box 3 – You are 65+ and ineligible for Medicare. A letter from the Social Security Administration stating ineligibility should accompany this form.

SECTION III – Address Information

Benefit Recipient Residential Address: Enter your address on the left side of this section.
Other Addressee: If another person handles your personal affairs, complete the "Other Addressee" section. The relationship space should be filled with one of the following:
1. Custodial Parent 2. Trustee 3. Power of Attorney 4. Legal Guardian
Date of Relationship: Enter the date that the "Other Addressee" was effective. **Send Mail to this Address (Y/N):** You can choose to have mail sent to your "Other Addressee" by entering (Y) for yes in the "Send Mail to this Address" field. If you want mail sent to both addresses, enter (Y) for yes in both "Send Mail to this Address" fields.

SECTION IV – Type of Enrollee

Check the box that reflects the Dependent Beneficiary's appropriate eligibility status:
Benefit Recipient Survivor of a Benefit Recipient, COBRA (only applicable if you have had coverage under the College Insurance Program as a Benefit Recipient or a Dependent Beneficiary).
Reason for Enrollment: This field should be completed with one of the following:
1. Application for Annuity 2. Benefit Recipient Turns 65
3. Coverage Terminated by Employer 4. Benefit Choice
Additional information on these four enrollment periods is located in the Benefits Handbook.
Type of Enrollee: SURS Staff will complete this information.

SECTION V – Survivor Information

If you are enrolling as a survivor, please complete this section.

SECTION VI – Health Plan

If you are choosing: **College Choice Health Plan (CCHP)** check box 1; if you are choosing either an **HMO or the OAP Plan**, check box 2. **If you checked box 2, please indicate the name of the plan and enter the plan carrier code (2 characters).** Carrier codes are listed on page 3. **Enter the provider identifier (6 or 10 characters),** which can be found in the managed care provider directory of your chosen plan.

SECTION VII – Coordination of Benefits

If you are enrolled in another group health or dental plan, you must submit a copy of your health and/or dental card to your GIR.

**College Insurance Program
Dependent Beneficiary Group Insurance Form**



CIP Benefit Recipient Name _____ SSN _____ - _____ - _____

Initial Enrollment **Benefit Choice** (July 1 effective date) Phone # () _____ - _____

Complete this form if you are enrolling an eligible Dependent Beneficiary. If you need additional dependent forms, please contact SURS.

SECTION I Dependent's Personal Information (Please print or type):

Dependent SSN _____ - _____ - _____ Effective Date of Enrollment _____ - _____ - _____
 Last Name _____ First _____ Middle _____
 Birthdate (mm/dd/ccyy) _____ - _____ - _____ Sex (M/F) _____ Retirement Date (mm/dd/ccyy) _____ - _____ - _____

SECTION II Dependent's Medicare Status (check one):

- 1 Non-Medicare
- 2 Medicare Eligible age 65+
- 3 Medicare Ineligible age 65+
- 4 Medicare Disability
- 5 End Stage Renal Disease

Medicare Number _____

If 2, 4 or 5 was checked, complete the following and submit a copy of your Medicare card(s):

Part A (Begin Date) _____ - _____ - _____
 Part B (Begin Date) _____ - _____ - _____
 Part D (Begin Date) _____ - _____ - _____
 Part A Free (Y) _____ (N) _____

SECTION III Dependent's Address Information:

Dependent Beneficiary Residential Address
(If different than Benefit Recipient)

 City _____
 State _____ ZIP Code _____ + _____
 County of Residence _____
 Country _____
 (for foreign address only)
 Send Mail to this Address (Y/N) _____

Other Addressee Name and Address:

Name _____
 Address _____
 City _____
 State _____ ZIP Code _____ + _____
 Country _____
 (for foreign address only)
 Addressee SSN _____ - _____ - _____
 Relationship _____
 Date of Relationship _____ - _____ - _____
 Send Mail to this Address (Y/N) _____

SECTION IV Relationship (Check One): Supporting documentation is required to add a dependent.

- | | |
|---|---|
| 1 Spouse <input type="checkbox"/> | 7 Adjudicated Child <input type="checkbox"/> |
| 2 Natural Child <input type="checkbox"/> | 8 Student <input type="checkbox"/> |
| 3 Adopted Child <input type="checkbox"/> | 9 Handicapped <input type="checkbox"/> |
| 4 Stepchild <input type="checkbox"/> | 10 Parent <input type="checkbox"/> |
| 5 Recognized Child <input type="checkbox"/> | 11 Sponsored Adult Child <input type="checkbox"/> |
| 6 Legal Guardian <input type="checkbox"/> | 13 Veteran Adult Child <input type="checkbox"/> |

Reason for Enrollment _____

SECTION V Health Plan:

(Check plan of Benefit Recipient)
 College Choice Health Plan (CCHP)
 HMO or OAP Plan

If choosing an HMO or the OAP plan, please provide the following:

Plan Name _____
 Plan Carrier Code (2 characters) _____
 Provider Identifier (6 or 10 characters) _____

SECTION VI Coordination of Benefits:

If you are enrolled in another group health or dental plan you must provide a copy of your health and/or dental card to your RGI

The authorization for my Dependent Beneficiary coverage election is to remain in effect until I provide written notice to the contrary. The statement and answers contained in this application are complete and true. I agree to abide by all rules and to furnish any additional information requested. My signature below confirms that I understand all above options selected and authorize the release of information to the health plan I select and the State of Illinois.

CIP Benefit Recipient Signature _____ Date _____ - _____ - _____

(Signature required)

Instruction Sheet for Dependent Beneficiary College Insurance Program

Complete this form and mail to:

State Universities Retirement System, P.O. Box 2710, Champaign, IL 61825-2710

This form is used for initial enrollment of a Dependent Beneficiary into the College Insurance Program (CIP) and to make changes during the annual Benefit Choice Period. For Benefit Choice Period changes, you need only complete the sections that have changes. Be sure to provide your (the person receiving the annuity) and your dependent's complete name and Social Security Number (SSN). If you are enrolling a Dependent Beneficiary in CIP for the first time during the annual Benefit Choice Period, check the Initial Enrollment box and the Benefit Choice box. For initial enrollment in CIP outside the Benefit Choice Period, check the Initial Enrollment box and complete the entire form.

SECTION I - Dependent Beneficiary's Personal Information

Dependent SSN: Enter the Dependent Beneficiary's Social Security Number. **Effective date of enrollment:** Enter the date coverage is effective (see the Benefits Handbook for coverage effective dates). **Name:** Enter the Dependent Beneficiary's complete name. **Birthdate:** Enter two-digit month, two-digit day and four-digit year. Example: 07/28/1945. **Sex:** M=Male, F=Female. **Retirement Date:** If your Dependent Beneficiary is retired, enter the retirement date.

SECTION II - Dependent Beneficiary's Medicare Status

Medicare Status - Check the box that correctly reflects the Dependent Beneficiary's Medicare status.

Medicare Box 1 - The Dependent Beneficiary is under 65 years of age and ineligible for Medicare due to age.

Medicare Box 2, 4 or 5 - Provide specific Part A, Part B and/or Part D dates and indicate whether Part A of Medicare is free. A copy of the Medicare card(s) must accompany this form.

Medicare Box 3 - The Dependent Beneficiary is 65+ and ineligible for Medicare. A letter from the Social Security Administration stating the Dependent Beneficiary's ineligibility should accompany this form.

SECTION III - Dependent Beneficiary's Address

Dependent Beneficiary Residential Address: Enter the Dependent Beneficiary's address only if it is different from the member's address. **Other Addressee:** If another person handles the Dependent Beneficiary's personal affairs, complete the "Other Addressee" section. The relationship space should be filled with one of the following:

1. Custodial Parent
2. Trustee
3. Power of Attorney
4. Legal Guardian

Date of Relationship: Enter the date that the dependent's relationship with the other addressee was effective. **Send Mail to this Address (Y/N):** You can choose to have mail sent to your other addressee by entering (Y) for yes in the "Send Mail to this Address" field. If you want mail sent to both addresses, enter (Y) for yes in both "Send Mail to this Address" fields.

SECTION IV - Dependent Beneficiary's Relationship

Check the box that reflects the correct relationship of the Dependent Beneficiary to the participant receiving an annuity. Birth Certificates are required when adding a dependent. The dependent types indicated below require additional documentation.

- 4 **Stepchild:** Written documentation from the Benefit Recipient that the child lives with them in a parent-child relationship.
- 6 **Legal Guardian:** A copy of the court decree establishing the Benefit Recipient as legal guardian for a child under 18 years of age.
- 7 **Adjudicated Child:** A copy of the court decree establishing the Benefit Recipient's financial responsibility for the child's healthcare.
- 8 **Student:** A Dependent Coverage Certification Statement (CMS-138) and verification of full-time student enrollment in an accredited school.
- 13 **Veteran Adult Child:** Proof of Illinois residency and a Veterans' Affairs Release Form (DD-214) stating the date the adult child was released from service (or equivalent).

Reason for Enrollment: This field should be completed with one of the following codes:

1. Benefit Recipient Application for Annuity
2. Dependent Beneficiary Turns 65
3. Coverage Terminated by Employer
4. Benefit Choice

SECTION V - Health Plan

Dependents must be enrolled in the same plan as the Benefit Recipient.

If you are choosing: **College Choice Health Plan (CCHP)** check box 1, if you are choosing an **HMO or the OAP Plan**, check box 2. **If you checked box 2, please indicate the name of the plan and the plan's carrier code (2 characters).** Carrier codes are listed on page 3. **Enter the provider identifier (6 or 10 characters),** which can be found in the managed care provider directory of your chosen plan. *Enrolling in a health plan automatically enrolls you in the dental and vision plans.*

SECTION VI - Dependent Beneficiary's Coordination of Benefits

If you are enrolled in another group health or dental plan you must submit a copy of your other health and/or dental insurance card to your GIR.

