State of Illinois
Department of Central Management Services

State Employees Group Insurance Participation Election Form

NOTICE: COMPLETION OF THIS FORM IS REQUIRED and must be returned to the SURS office in order to establish your eligibility on the MyBenefits Marketplace.

Eligible members who have completed the vesting requirement of qualifying service as a Tier 1 or Tier 2 employee may elect to participate in the State of Illinois Group Insurance Program at the time of their retirement. Participation in the state health/dental program is **optional**.

Eligible members electing not to participate in the state health/dental program are eligible to participate at a later date by enrolling during the annual open enrollment period or upon experiencing a qualifying change in status event that allows a member to enroll. Members will still be eligible for and enrolled in the state life insurance program through MyBenefits Marketplace.

MyBenefits Marketplace is a customized website just for you, and you will be required to register on the website using information pertinent to you for self-authentication. Once registered, you will be provided your CMS-issued Employee ID Number (EIN), which you will need whenever you login to this site.

Additional information concerning benefit coverage is located on the MyBenefits Marketplace, at www.MyBenefits.illinois.gov, or you may call a Customer Service Representative Monday – Friday 8:00 a.m. – 6:00 p.m. CST toll free at 1-844-251-1777 TTY toll free 1-844-251-1778.

Please make an election

- ☐ I elect to participate in the State Employees Group Insurance Program
- ☐ I do not elect to participate in the State Employees Group Insurance Program
- ☐ I am not eligible for or enrolled in Medicare and wish to enroll in the Opt-Out Financial Incentive Program. By enrolling in the Financial Incentive Program, I will receive $150 per month *(less than 20 years of service)* or $500 per month *(20 or more years of service)*. I understand I will be enrolled with life insurance coverage only.
  - ☐ The Financial Incentive packet is attached
  - ☐ Please send me the Financial Incentive packet
- ☐ **I am currently enrolled as a dependent** on my State-covered spouse’s or civil union partner’s health, dental, and vision insurance coverage **for at least one year**, and therefore, qualify to remain on my spouse’s or civil union partner’s State insurance as a dependent. I understand that waiving my coverage as an annuitant to remain a dependent of my spouse or civil union partner will mean that the only coverage I will have as an annuitant (member) will be life insurance coverage.

I authorize premiums as established annually to be deducted from my pension check. I understand that if I do not receive a pension check from SURS or if my check is insufficient to cover the insurance premiums, I will be billed directly.

Signature ____________________ Member I.D. ____________ Date ____________

E-mail Address ____________________ Telephone Number ____________________

Submit completed form to:
SURS
1901 Fox Dr
Champaign, IL 61820