



ILLINOIS
DEPARTMENT OF CENTRAL
MANAGEMENT SERVICES
PO Box 19208, Springfield IL 62794-9208

STATE EMPLOYEES'
MCAP ENROLLMENT FORM FY2016
MEDICAL CARE ASSISTANCE PLAN (MCAP)
ENROLLMENT FORM for the **FY2016 PLAN YEAR**
(Begins July 1, 2015)

The MCAP program is for reimbursement of eligible medical expenses, such as copayments, deductibles, eligible over-the-counter items, etc., for the member and any eligible dependents. All medical care expenses and services must be rendered prior to June 30, 2016, in order to be eligible for reimbursement.

Last Name	First	Middle Initial	Social Security #
Street	City	State	Zip Code
Primary Phone	Secondary Phone		

- Benefit Choice**
- Initial Enrollment (due o beginning employment) - New Hire Date:**
- Mid-Year Enrollment—Change in Status Code required (see chart below)**

I certify that the above eligible change in status event occurred on _____ and that the change is **on account of and consistent with** the nature of the qualifying event.

$$\begin{array}{c}
 \$ \underline{\hspace{2cm}} \div \\
 \text{Total Annual MCAP Amount} \\
 \text{(Annual Minimum = \$240)} \\
 \text{(Annual Maximum—\$2,550)}
 \end{array}
 =
 \begin{array}{c}
 \underline{\hspace{2cm}} \\
 \text{\# of Deductions}
 \end{array}
 =
 \begin{array}{c}
 \$ \underline{\hspace{2cm}} \\
 \text{Amount Per Pay Period}
 \end{array}$$

*Benefit Choice enrollment—enter either 12 or 24 (may be less for a university employee);
Midyear enrollment—enter the number of deductions remaining in the plan year.

Change in Status Code Chart

01 Birth or adoption of dependent * (employee must be on payroll in order to enroll)	11 Employee returns to payroll (from being on a leave of absence)
02 Marriage	13 Employee changes employment status from Part-time less than 50% to greater than 50%
03 Divorce, legal separation or annulment *	15 Spouse or dependent terminates employment
07 Change of county of residence/worksite for employee or spouse *	17 Spouse or dependent changes employment status from Full-time to Part-time
08 Judgment, decree or court order *	20 Spouse enters leave of absence and loses FSA enrollment
10 Employee commences employment	24 Coordination of spouse's annual benefit election period †

*** Reviewed case-by-case**

† Change in Status codes indicated with this symbol must include a written statement indicating that the change your spouse made during their annual benefit election period is **on account of and consistent with** the change you are requesting.

I understand and certify that:

- I may not change or stop my account deposits during the plan year unless I experience a qualifying change in status.
- I understand that I must submit reimbursement claims for medical expenses that were incurred on or prior to June 30th by the last day of the run-out period which is 90 days after the last day of the plan year (i.e., September 30th).
- I understand that if I am an eligible employee and have a balance remaining for the current plan year account after the run-out period has expired, up to \$500 of that balance will be carried over to the next plan year, regardless of whether or not I enroll in MCAP through the State for the next plan year and that any amount over \$500 will be forfeited.
- I understand that deductions must continue during any paid leave of absence.
- I intend to participate in MCAP for the entire plan year. I do not anticipate terminating state service, retiring or going on an unpaid leave of absence.
- I will refund to CMS any incorrect reimbursements or ineligible payments. If I do not repay the debt, the State may take whatever steps necessary to collect the amount owed, up to and including filing an order of involuntary withholding through the Office of the Comptroller.
- I understand that the IRS Grace Period that applied to previous plan years will no longer apply to this plan year or future plan years.
- If my payroll deductions cease for any reason, I understand my participation in the program will terminate on the last day of the pay period in which a check was issued, unless I elect to continue my participation through direct payments to the FSA Unit for the remainder of the plan year.
- To the best of my knowledge, the information on this form is accurate. I am responsible for any discrepancies that may affect my status with the IRS.

By signing this form, I authorize the State of Illinois to deduct the amount indicated from each paycheck for my MCAP account.

Employee Signature: _____ DATE _____

GIR USE Only	Org Proc Code: _____ Pay Code: _____ Telephone: _____
	Effective Date: ____/____/____ Deduction Start Date: ____/____/____
	Enter a Deduction End Date if enrollment is for a university employee paid over 9 months: ____/____/____
	GIR Signature: _____ Date: ____/____/____
GIR Instructions: Forward a copy to the FSA Unit at CMS, a copy to payroll and retain a copy in the member's file.	