



Please return form to:

FOR POSITION ONLY

Preprinted Name
 Preprinted Address
 Address Line 2
 City, State and Zip Code
 Intelligent Mail Barcode

FOR POSITION ONLY

Preprinted Retirement System
 Name
 and Address

IF THE ABOVE PREPRINTED MAILING ADDRESS IS INCORRECT, ENTER THE CORRECT ADDRESS ON THESE LINES.

Complete SECTION 1 if you are ENROLLING IN A MEDICARE ADVANTAGE PLAN FOR THE FIRST TIME. If you're a current TRAIL member and have no changes, disregard this form and your TRAIL MAPD coverage will continue.

SECTION 1: MEMBER INFORMATION

Please fill in the information below as it is on your Medicare card.

MEDICARE HEALTH INSURANCE

 Last Name

 Date of Birth

Gender M F

 First Name MI

 Social Security Number

 Medicare Claim Number

 Email Address

Is Entitled to

HOSPITAL (PART A) _____
 Effective Date

 Home Phone Cell Phone

MEDICAL (PART B) _____
 Effective Date

 County of Residence

Do you have End-Stage Renal Disease (ESRD)? Yes No

SECTION 2: RESIDENTIAL ADDRESS

RESIDENTIAL ADDRESS (if different from **mailing** address)

You must enter a physical location in the section below if the address preprinted above is a P.O. Box (Do not enter a P.O. Box or a General Delivery Address)

Do you reside in a nursing home or assisted living facility? Yes No

If YES, the nursing home/assisted living facility address must be entered below:

 Street Address

 Apt. or Suite

 City

 State

 Zip Code

 County

Complete **SECTION 3** if you are (1) **ENROLLING IN A MEDICARE ADVANTAGE PLAN FOR THE FIRST TIME**, (2) **WISH TO CHANGE** your current Medicare Advantage health plan or dental election or are (3) **ELECTING TO OPT OUT** of the State's coverage.

SECTION 3: COVERAGE ELECTIONS for 2017

OUR SYSTEM SHOWS YOUR CURRENT COVERAGE IS:

FOR POSITION ONLY

Health Plan Name

FOR POSITION ONLY

Dental Election Name

DEPENDENT COVERAGE - Any currently enrolled dependent on your State of Illinois coverage will remain enrolled and will have the same coverage you have. If you change your health plan your dependent must sign page 3. To add or drop a dependent, complete page 4.

HEALTH PLAN ELECTION (select one)

Preferred Provider Organization (PPO) - available nationwide

UnitedHealthcare PPO (AE)

OR

Health Maintenance Organization (HMO) (See map on page 16 of the Decision Guide)

Check a box below to indicate your HMO plan election:

Coventry Advantra HMO (AB)

Member's PCP name _____ Spouse/Partner's PCP _____ Other Dependent PCP _____

Physician's NPI# _____ Physician's NPI# _____ Physician's NPI# _____

Health Alliance MAPD HMO (AF)

Member's PCP name _____ Spouse/Partner's PCP _____ Other Dependent PCP _____

Physician's NPI# _____ Physician's NPI# _____ Physician's NPI# _____

Humana Health Plan HMO (AD)

Member's PCP name _____ Spouse/Partner's PCP _____ Other Dependent PCP _____

Physician's PCP# _____ Physician's PCP# _____ Physician's PCP# _____

Humana Benefit Plan HMO (AC) (Livingston and Knox Counties Only)

Member's PCP name _____ Spouse/Partner's PCP _____ Other Dependent PCP _____

Physician's PCP# _____ Physician's PCP# _____ Physician's PCP# _____

OR, OPT OUT OF TRAIL MEDICARE ADVANTAGE

I wish to opt out of the State's Medicare Advantage TRAIL Program. I understand that by opting out I will no longer have health, prescription or EyeMed vision coverage through the State of Illinois effective January 1, 2017. I also understand that I cannot opt back into the health, prescription and vision coverage until a future TRAIL Medicare Advantage Open Enrollment Period.

DENTAL ELECTION - Complete only if you wish to change your DENTAL election.

I **want** dental coverage through Delta Dental. I **don't want** dental coverage.

LIFE INSURANCE ELECTION

Life insurance options for annuitants and survivors vary and are limited. If you would like to change your life insurance coverage, contact your retirement system (on the front of this form). Medical underwriting will be required to add or increase Member Optional Life. A Statement of Health (underwriting) application is available by calling Minnesota Life at (888) 202-5525 or on the TRAIL website at www.cms.illinois.gov/thetrail.

SECTION 4: SIGNATURE OF PLAN PARTICIPANTS

By signing below, I am agreeing that I have read and understand the important information on page iii of the Instruction Sheet. I also understand that if I am changing health plans or adding a dependent, my dependent must also sign.

SIGNATURE OF MEMBER or authorized legal representative
 (including valid Power of Attorney, Legal Guardian, etc.)

 Date

SIGNATURE OF SPOUSE/CIVIL UNION PARTNER or authorized
 legal representative (including valid Power of Attorney, Legal Guardian, etc.)

 Date

SIGNATURE OF OTHER DEPENDENT or authorized legal
 representative (including valid Power of Attorney, Legal Guardian, etc.)

 Date

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an authorized individual, the signature certifies that: (1) this person is authorized under State law to complete this enrollment and (2) documentation of this authority is available upon request by the Plan or Medicare.

AUTHORIZED LEGAL REPRESENTATIVE

If you are the authorized legal representative, you **must** sign the ‘Signature of Member’ above and provide the following information:

 Last Name

 First Name

 Street Address

 Apt. or Suite

 City

 State

 Zip Code

 Phone Number

 Relationship to Member

As the legal representative of the member, I would like the State of Illinois TRAIL healthcare insurance information mailed to my address.

Documentation Required

If you are the legal representative signing for this member you must provide a copy of the legal document giving this authority, such as a Power of Attorney or a court order indicating that you are the member’s legal guardian, along with this application. If the documentation is not submitted by the application due date, the application will be denied. **Members whose application is denied due to lack of documentation from the legal representative will not have health, prescription drug or vision coverage through the State of Illinois and will not be allowed to re-enroll in the program until a future TRAIL Medicare Advantage Open Enrollment Period.**

Complete **Section 5** if you wish to **add or drop a Medicare dependent** (spouse/partner or child). If you wish to add a Non-Medicare dependent, see page iv of the Instruction Sheet.

SECTION 5: DEPENDENT COVERAGE

1. Drop a Dependent - if you wish to **drop** a currently enrolled dependent from your coverage, check the box for the relationship of the dependent you are dropping. If the dependent is a child, indicate the first name of the child. Coverage will be terminated effective January 1, 2017.

Spouse or Civil Union Partner

Child, indicate name: _____

2. Add a Dependent - if you wish to **add** a dependent to your Medicare Advantage plan coverage, complete the information below. **You may only use this form to add a dependent that has Medicare Parts A and B.** Please fill in the information below as it appears on your dependent's Medicare card. Documentation, as indicated on page iv of the Instruction Sheet, is required to add a dependent. Dependent must sign page 3.

Dependent 1: Relationship of Dependent to Member

Spouse Child

Civil Union Partner

MEDICARE HEALTH INSURANCE

Last Name

First Name MI

Medicare Claim Number

Is Entitled to
HOSPITAL (PART A) _____
Effective Date

MEDICAL (PART B) _____
Effective Date

Date of Birth Gender M F

Dependent's Social Security Number

Does this dependent have End-Stage Renal Disease (ESRD)? Yes No

Dependent 2: Relationship of Dependent to Member

Spouse Child

Civil Union Partner

MEDICARE HEALTH INSURANCE

Last Name

First Name MI

Medicare Claim Number

Is Entitled to
HOSPITAL (PART A) _____
Effective Date

MEDICAL (PART B) _____
Effective Date

Date of Birth Gender M F

Dependent's Social Security Number

Does this dependent have End-Stage Renal Disease (ESRD)? Yes No