



Complete **SECTION 3** if you are **ENROLLING IN A MEDICARE ADVANTAGE PLAN FOR THE FIRST TIME, WISH TO CHANGE** your current Medicare Advantage health plan election or are **ELECTING TO CANCEL** your CIP coverage.

### SECTION 3: 2015 COVERAGE ELECTIONS

**OUR SYSTEM SHOWS YOUR CURRENT HEALTH PLAN IS:**

**DEPENDENT COVERAGE** - If you have a spouse, civil union partner, parent or disabled child currently enrolled on your CIP coverage, they will remain enrolled and will have the same coverage that you have. If you change your health plan or add a dependent to your coverage, your dependent must also sign page 3. To add or drop a dependent, complete page 4.

#### HEALTH PLAN ELECTION

**Preferred Provider Organization (PPO) - available nationwide**

UnitedHealthcare PPO (AE)

**Health Maintenance Organization (HMO)**

(availability varies by Illinois county - see map on page 14 of the TRAIL Decision Guide)

**Check the box for your HMO plan election:**

Coventry Advantra HMO (AB)

Humana Health Plan HMO (AD)

Health Alliance MAPD HMO (AF)

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

**Enter the Primary Care Physician's (PCP) name and either the NPI or PCP number below:**

(NPI and PCP numbers can be found on the plan's website or by calling the plan)

\_\_\_\_\_  
Member's PCP Name

\_\_\_\_\_  
Spouse/Partner's PCP Name

\_\_\_\_\_  
Other Dependent PCP Name

\_\_\_\_\_  
Member's NPI or PCP#

\_\_\_\_\_  
Spouse/Partner's NPI or PCP#

\_\_\_\_\_  
Other Dependent NPI or PCP#

#### CANCEL MY CIP COVERAGE

**I wish to cancel my CIP coverage. I understand that by cancelling I will no longer have health, prescription drug, dental and vision coverage through CIP effective January 1, 2015.** I also understand that under current CIP eligibility rules, that if I cancel my coverage I will be ineligible to re-enroll in the program in the future unless I lose other group insurance coverage for reasons other than voluntary termination or nonpayment of premium.

## SECTION 4: SIGNATURE OF ENROLLEES

**By signing below, I am agreeing that I have read and understand the important information on page iii of the Instruction Sheet.**

\_\_\_\_\_  
**SIGNATURE OF APPLICANT** 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 (as described above), 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 Applicant' above and provide the following information:

\_\_\_\_\_  
Last Name

\_\_\_\_\_  
First Name

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Apt. or Suite

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Relationship to Applicant

I would like the enrollee's College Insurance Program (CIP) information mailed to my address.

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, dental and vision coverage through the College Insurance Program and will not be allowed to re-enroll in the program at any time in the future unless they lose their other coverage for reasons other than voluntary termination or nonpayment of premium.**

Complete **Section 5** if you wish to **add or drop a Medicare dependent** (spouse, civil union partner, parent 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, 2015.

Spouse or Civil Union Partner       Parent  
 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 is on your dependent's Medicare card. Documentation, as indicated on page iv of the Instruction Sheet, is required to add a dependent. To add more than two dependents, download a copy of this enrollment form from the TRAIL website.

**Dependent 1: Relationship of Dependent to Member**

Spouse       Child  
 Civil Union Partner  
 Parent

**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  
 Parent

**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