



State of Illinois Department of
Central Management Services
Bureau of Benefits—Group Insurance Division
CIP Open Enrollment Form

For coverage from February 1, 2014 through December 31, 2014

<i>First Name</i> _____
<i>Last Name</i> _____

Return **all 8 pages** of this form to your retirement system at the address shown below postmarked by **December 13, 2013**.
State University Retirement System
1901 Fox Drive
P.O. Box 2710
Champaign, IL 61825-2710

Member Information

Complete the member information below making sure to enter your physical residential street address, EVEN IF you receive your mail at a Post Office box.

<i>Residential Address</i> (No P.O. Box)			
<i>City</i>	<i>State</i>	<i>Zip Code</i>	
<i>Home Phone</i>	<i>Cell Phone</i>		
<i>Email</i>			
<i>Social Security #</i>	<i>Gender</i> <input type="checkbox"/> M <input type="checkbox"/> F	<i>Date of Birth:</i> MM DD YYYY	

Complete this section to waive coverage starting February 1, 2014

If you do not wish to enroll in one of the State-sponsored Medicare Advantage plans being offered, the State requires that you affirmatively check the box below indicating that you do not want the coverage. Please mark the box below and sign this section. Once signed, simply return this form to your retirement system at the address above.

I do not want to enroll in the MA-PD coverage. I understand that my election means that my current medical, prescription drug, vision, and dental coverage will end January 31, 2014. I also understand that under the current CIP eligibility rules, if I do not elect an MA-PD plan at this time, I cannot re-enroll in CIP at any time in the future unless I lose other coverage for reasons other than voluntary termination or nonpayment of premium.

<i>Signature</i>	<i>Date</i>
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If you are the authorized representative, you must sign above and provide the following information.

<i>Representative's Name</i>	<i>Address</i>
<i>Phone Number</i>	<i>Relationship to Member</i>



Healthcare Plan Election

Medical Options: To have medical and prescription drug coverage after January 31, 2014, please make your election by checking the box next to one of the MA-PD plans below. See the map in the enclosed Your Retiree Healthcare Decision Guide for plans available in your area. All covered family members will be enrolled in the same plan. Vision and dental coverage for you and your dependents will be provided automatically if you elect one of the new MA-PD plans (options indicated below):

- | | |
|---|---|
| <input type="checkbox"/> Coventry Advantra HMO (AB) | <input type="checkbox"/> Humana Benefit Plan HMO (AC) |
| <input type="checkbox"/> UnitedHealthcare Group Medicare Advantage PPO (AE) | <input type="checkbox"/> Humana Health Plan HMO (AD) |

If you elected HMO coverage, you must select a primary care physician (PCP) for each covered person. Use the provider directory provided by Humana or Coventry Advantra to select a PCP for you and your dependents. Each person on the plan may select a different PCP. The directories include both the name of the physician and the required 10-digit "PCP Number" for each physician.

PCP for Member

<i>Name</i>	<i>PCP Number</i>
<i>Current patient of PCP?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No	

PCP for Spouse/Civil Union Partner

<i>Name</i>	<i>PCP Number</i>
<i>Current patient of PCP?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No	

PCP for Other Dependent 1

<i>Name</i>	<i>PCP Number</i>
<i>Current patient of PCP?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No	

PCP for Other Dependent 2

<i>Name</i>	<i>PCP Number</i>
<i>Current patient of PCP?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No	



Dependent Elections

Please select all the actions in this section that apply.

I wish to continue coverage for my currently enrolled dependents.

I wish to drop my: Spouse/Civil Union Partner

Other Dependent (enter dependent's name) _____

If adding a dependent, you must complete the "Dependent Information" section on page 4. If the dependent is enrolled in Medicare Parts A **and** B, you must also enter the Medicare ID card number and effective date information. Documentation is required to add any dependent. Documentation requirements are listed on page 8.

I wish to add a: Spouse/Civil Union Partner who is enrolled in Medicare Parts A **and** B

Other Dependent who is enrolled in Medicare Parts A **and** B

I wish to add a: **Non-Medicare*** Spouse/Civil Union Partner

Non-Medicare* Other Dependent

* Non-Medicare means the dependent is not enrolled in Medicare Parts A **and** B. If you are adding a non-Medicare dependent, you will not be allowed to change to one of the new MA-PD plans at this time; you will instead, remain in your current health plan until your dependent either enrolls in Medicare Parts A **and** B, or your dependent is dropped from your CIP coverage.



Dependent Information

Complete the section below for each dependent that you are adding to your coverage. If you are adding your eligible spouse, civil union partner or dependent, you must provide the necessary documentation to add the dependent, in addition to providing Medicare Part A **and** Part B information for each person being added. Complete the section below only if you are adding a dependent. **If you are NOT adding any dependents, skip to page 5.**

Spouse/Civil Union Partner of Member

<i>First Name</i>	<i>Middle Name</i>	<i>Last Name</i>		
<i>Relationship to Retiree</i>				<i>Gender</i> <input type="checkbox"/> M <input type="checkbox"/> F
<i>Social Security #</i>		<i>Date of Birth</i>	<i>MM</i>	<i>DD</i> <i>YYYY</i>

Spouse/Civil Union Partner—Medicare Health Insurance

If this dependent does **not** have Medicare Parts A and B, check this box and continue to the next section.
 If the dependent **does** have Medicare Parts A and B, use the information on the dependent's Medicare card to complete this section. Either fill in the blanks below so they match the red, white and blue Medicare card **OR** attach a copy of the Medicare card.

<i>Medicare Claim Number</i>					
<i>IS ENTITLED TO:</i>		HOSPITAL (Part A)		MEDICAL (Part B)	
<i>Effective Date</i>	<i>MM</i>	<i>YY</i>	<i>Effective Date</i>	<i>MM</i>	<i>YY</i>

Other Dependent

<i>First Name</i>	<i>Middle Name</i>	<i>Last Name</i>		
<i>Relationship to Retiree</i>				<i>Gender</i> <input type="checkbox"/> M <input type="checkbox"/> F
<i>Social Security #</i>		<i>Date of Birth</i>	<i>MM</i>	<i>DD</i> <i>YYYY</i>

Other Dependent Health Insurance

If this dependent does **not** have Medicare Parts A and B, check this box and continue to the next section.
 If the dependent **does** have Medicare Part A and B, use the information on the dependent's Medicare card to complete this section. Either fill in the blanks below so they match the red, white and blue Medicare card **OR** attach a copy of the Medicare card.

<i>Medicare Claim Number</i>					
<i>IS ENTITLED TO:</i>		HOSPITAL (Part A)		MEDICAL (Part B)	
<i>Effective Date</i>	<i>MM</i>	<i>YY</i>	<i>Effective Date</i>	<i>MM</i>	<i>YY</i>



All Individuals Enrolling in Coverage Must Answer These Questions

Questions for Member

Do you work? Yes No *If you have insurance provided by your employer, complete the information below:*

Insurance Plan Name Effective Date MM YY

Questions for Spouse/Civil Union Partner

Do you work? Yes No *If you have insurance provided by your employer, complete the information below:*

Insurance Plan Name Effective Date MM YY

Do you have End-Stage Renal Disease (ESRD)? *If you have had a successful kidney transplant and/or you do not need regular dialysis any more, please attach a note or records from your doctor indicating such; otherwise, we may need to contact you to obtain additional information.* Yes No

If yes, what is the date of your first dialysis treatment: Month Year

Questions for Other Dependent 1

Do you work? Yes No *If you have insurance provided by your employer, complete the information below:*

Insurance Plan Name Effective Date MM YY

Do you have End-Stage Renal Disease (ESRD)? *If you have had a successful kidney transplant and/or you do not need regular dialysis any more, please attach a note or records from your doctor indicating such; otherwise, we may need to contact you to obtain additional information.* Yes No

If yes, what is the date of your first dialysis treatment: Month Year

Questions for Other Dependent 2

Do you work? Yes No *If you have insurance provided by your employer, complete the information below:*

Insurance Plan Name Effective Date MM YY

Do you have End-Stage Renal Disease (ESRD)? *If you have had a successful kidney transplant and/or you do not need regular dialysis any more, please attach a note or records from your doctor indicating such; otherwise, we may need to contact you to obtain additional information.* Yes No

If yes, what is the date of your first dialysis treatment: Month Year



AUTHORIZATION, CERTIFICATION, AGREEMENT

Read this section carefully.

I authorize premiums as established annually to be deducted from my pension check for those plans I have selected. I understand that if my pension check is insufficient, I will be direct billed. The information contained in this Form is complete and true. I agree to abide by all College Insurance Program rules. I agree to furnish additional information requested for enrollment and administration of the plan I have elected. I understand it is my responsibility to review my pension check and verify that the amounts of the insurance deductions are accurate. I understand that if my deductions are not correct I must immediately contact my retirement system.

I certify that, to the best of my knowledge, the information provided on this form is true and accurate and that any dependents listed are eligible for coverage under the criteria described on page 8. I understand that I must notify the State Universities Retirement System within 30 days of the date any dependent ceases to be eligible for coverage. The State of Illinois, Department of Central Management Services (CMS) may impose a financial penalty, including, but not limited to, repayment of all premiums the Program made on behalf of the enrolled individuals, as well as expenses incurred by the Program.

By completing this enrollment application, I agree to the following:

- The Medicare Advantage plans with prescription drugs (MA-PD plans) have contracts with the Federal government. I can be in only one MA-PD plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health and prescription drug plan. Once I enroll, I may leave this plan or make changes only at certain times of the year if an enrollment period is available or under certain special circumstances.
- The MA-PD HMO networks serve specific areas. If I move out of that service area, I need to notify my retirement system so I can disenroll and find a new plan in my new area.
- Once I am a member of an MA-PD plan, I have the right to appeal plan decisions about payment or service if I disagree. I will read the Evidence of Coverage document from the plan I have chosen when I get it to know which rules I must follow to get coverage with this MA-PD plan. I understand that people with Original Medicare are not usually covered under Medicare while out of the country except for limited coverage near the U.S. border. I may also be disenrolled if I do not pay any applicable plan premiums within the grace period. The effective date of disenrollment is in accordance with Federal requirements.
- I understand that, if electing an MA-PD HMO plan, beginning on the date MA-PD HMO plan coverage begins, I can only use network providers, except for emergency or urgently needed services or out-of-area dialysis services. I also understand that I will have to pay more for services that I receive from non-network providers. Services authorized by the plan and other services contained in my Medicare plan Evidence of Coverage document (also known as the member contract or subscriber agreement) will be covered.
- I understand that the providers in the networks are independent contractors in private practice and are neither employees nor agents of MA-PD plans or their affiliates.

Release of Information: By joining an MA-PD health plan, I acknowledge that they will release my information to Medicare and other plans as is necessary for treatment, payment of claims and health care operations. Medicare may also use this information for research and other reasons which they can do under Federal law.



Signatures—All Enrollees (Current and New) Must Sign

Member

Signature *Date*

If you are the authorized representative, you must sign above and provide the following information.

<i>Representative's Name</i>	<i>Address</i>
<i>Phone Number</i>	<i>Relationship to Enrollee</i>

Spouse/Civil Union Partner

Signature *Date*

If you are the authorized representative, you must sign above and provide the following information.

<i>Representative's Name</i>	<i>Address</i>
<i>Phone Number</i>	<i>Relationship to Enrollee</i>

Other Dependent 1

Signature *Date*

If you are the authorized representative, you must sign above and provide the following information.

<i>Representative's Name</i>	<i>Address</i>
<i>Phone Number</i>	<i>Relationship to Enrollee</i>

Other Dependent 2

Signature *Date*

If you are the authorized representative, you must sign above and provide the following information.

<i>Representative's Name</i>	<i>Address</i>
<i>Phone Number</i>	<i>Relationship to Enrollee</i>

You must return all 8 pages of this form to your retirement system.



Dependent Documentation Requirements

If you are adding a dependent who is not enrolled in Medicare Parts A **and** B, you will not be allowed to enroll in one of the MA-PD plans. You may add your dependent during the Open Enrollment Period, but you will remain in your current health plan until that dependent either becomes eligible for and enrolls in Medicare Parts A **and** B, or the dependent is dropped from your coverage. The effective date of the dependent’s coverage will be February 1, 2014.

If you are *adding* a dependent for the first time, you must provide your retirement system with the appropriate documentation as indicated below:

Relationship of Dependent To You	Documentation Required
Spouse or Civil Union Partner	Marriage certificate or civil union partnership certificate
Natural Child through age 25	Birth certificate
Stepchild or civil union partner’s child through age 25	Birth certificate indicating your spouse/civil union partner is the child’s parent, and Marriage/civil union partnership certificate indicating the child’s parent is your spouse/civil union partner
Adopted Child through age 25	Adoption certificate stamped by the circuit clerk
Adjudicated Child/Legal Guardianship through age 25	Court documentation signed by a judge
Parent	Birth certificate of member indicating parent’s name and Copy of the member’s tax return
Adult Veteran Child (IRS/non-IRS) through age 29	Birth certificate, and Proof of Illinois residency, and Veterans’ Affairs Release form DD-214 (or equivalent), and a Copy of the member’s tax return
Disabled	Birth certificate, and a Statement from the Social Security Administration with the Social Security disability determination, and a Copy of the member’s tax return for dependents 26 and older