February 12, 2014

Case ID: 066066010011Y

Dear HH_NAME (NMG_NULL_ENGLISH),

It is time to renew your medical coverage!
It’s time for renewal, also known as “redetermination” or “re-de.”

Here’s what to do:

1. Answer all questions on this form.
2. Make sure all the information is correct. If any information is wrong, cross it out and write in the correct information.
3. Sign this form at the bottom of page 4.
4. Attach proof documents for income and expenses and other proofs we ask for.
5. Send your signed form and all proofs by February 25, 2014.

Send your form and proofs to us one of these ways:

→ Fax your form and proofs to 1-866-661-7025
→ Mail your form and proofs in the envelope that we sent you
→ E-mail your form and proofs to www.medredes.hfs.illinois.gov

Your medical benefits may end if you do not send your proofs by February 25, 2014.

Call us at 1-855-458-4945 (TTY: 1-855-694-5458) if you cannot send everything on time or if you have questions. We may be able to help you get the proofs you need.

Thank you,
Illinois Medicaid Redetermination

Questions? Call 1-855-458-4945 (TTY: 1-855-694-5458). The call is free!
Monday to Friday from 7 a.m. to 7:30 p.m. and Saturday from 8 a.m. to 1 p.m.
E-mail us at www.medredes.hfs.illinois.gov or send a fax to 1-866-661-7025.
Tenemos información en español, ¡Servicio de intérpretes gratis!
Llame al 1-855-458-4945.
Medical Renewal Form

1. Do these people still live with you?

MEMBER NAME1 01/01/1999 ☐ Yes ☐ No

2. Tell us about anyone else who lives with you:

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of birth</th>
<th>Relationship to you</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. Did you or anyone living with you get new health insurance in the last year? ☐ Yes ☐ No

If yes, name of insurance plan: ____________________________ Policy number: ____________________________

Who is covered by this health insurance? ____________________________________________________________

Name of insurance plan: ____________________________ Policy number: ____________________________

Who is covered by this health insurance? ____________________________________________________________

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4. Do you and everyone living with you still get this income from these sources?

<table>
<thead>
<tr>
<th>Income Source</th>
<th>Total per month</th>
<th>Is this correct?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salary, wages, and tips for everyone</td>
<td>$1111.99</td>
<td>Yes</td>
</tr>
<tr>
<td>Self-employment income for everyone</td>
<td>$2222.99</td>
<td>No</td>
</tr>
<tr>
<td>Unemployment for everyone</td>
<td>$3333.99</td>
<td>No</td>
</tr>
<tr>
<td>Social Security for everyone</td>
<td>$4444.99</td>
<td>No</td>
</tr>
<tr>
<td>Supplemental Security Income (SSI) for everyone</td>
<td>$9999.99</td>
<td>No</td>
</tr>
<tr>
<td>Workers’ Compensation benefits for everyone</td>
<td>$1199.99</td>
<td>No</td>
</tr>
<tr>
<td>Veterans benefits for everyone</td>
<td>$2299.99</td>
<td>No</td>
</tr>
<tr>
<td>Pension or retirement income for everyone</td>
<td>$5555.99</td>
<td>No</td>
</tr>
<tr>
<td>Spousal support or child support received by everyone</td>
<td>$6666.99</td>
<td>No</td>
</tr>
<tr>
<td>Rental fees or royalties for everyone</td>
<td>$7777.99</td>
<td>No</td>
</tr>
<tr>
<td>Other income for everyone</td>
<td>$3399.99</td>
<td>No</td>
</tr>
</tbody>
</table>

If you checked no for any income, write the correct amount in the next section.

5. Do you or anyone living with you get other income? Check all that apply.

- Salary, wages, and tips
- Self-employment
- Unemployment
- Social Security
- Supplemental Security Income (SSI)
- Workers’ Compensation benefits
- Veterans benefits
- Pension or retirement income
- Spousal support or child support
- Inheritance or trust fund
- Rental fees or royalties
- Other:__________________________

Attach proof of the amount for any income received in the last 30 days.
6. Do you or anyone living with you pay any of these expenses? Check all that apply.

- Spousal support or child support
  - How much?
  - How often?
- Child care expenses
  - How much?
  - How often?
- Employment expenses
  - How much?
  - How often?
- Other: ____________________________
  - How much?
  - How often?

⇒ Attach proof of all expenses paid in the last 30 days.

7. Do you or anyone living with you still own these resources (assets) with these values?

- Cash and bank accounts
  - Total $ 1111.00
  - Is this correct? □ Yes □ No
- Life insurance (cash value)
  - Total $ 2222.00
  - Is this correct? □ Yes □ No
- Burial fund or trust fund
  - Total $ 3333.00
  - Is this correct? □ Yes □ No
- Car, truck or motor vehicle
  - Total $ 8888.00
  - Is this correct? □ Yes □ No
- Other property or land
  - Total $ 5555.00
  - Is this correct? □ Yes □ No
- Mutual funds, stocks, bonds
  - Total $ 4444.00
  - Is this correct? □ Yes □ No
- 401(k), IRA or Keough accounts
  - Total $ 7777.00
  - Is this correct? □ Yes □ No
- Other resources
  - Total $ 6666.00
  - Is this correct? □ Yes □ No

⇒ If you checked no for any resources, write the correct values in the next section.

8. Do you or anyone living with you own other resources (assets)? Check all that apply.

- Cash and bank accounts
  - What is the value? $ _____________________
- Life insurance (cash value)
  - What is the value? $ _____________________
- Burial fund or trust fund
  - What is the value? $ _____________________
- Car, truck or motor vehicle
  - What is the value? $ _____________________
- Other property or land
  - What is the value? $ _____________________
- Mutual funds, stocks, bonds
  - What is the value? $ _____________________
- 401(k), IRA or Keough accounts
  - What is the value? $ _____________________
- Other: ____________________________
  - What is the value? $ _____________________

⇒ Attach proof showing who owns these resources and the current value.

You do not need to attach proof of the value of your vehicle or your home.

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9. **Read and sign below:**

- I understand that officials in charge of my health benefits may check all information on this form.
- I understand they may check my information electronically. If they ask for my help checking information, I must cooperate.
- I understand that anyone who knowingly lies or provides untrue information, or arranges for someone to knowingly lie or provide untrue information, or intentionally misuses the health benefits card issued by the State of Illinois, may be committing a crime which can be prosecuted or punished under federal law, state law, or both.
- If the Illinois Department of Healthcare and Family Services pays medical bills for me, the State of Illinois may collect my medical support payments instead of me.
- I am signing this form under the penalty of perjury. That means the information I have provided on this renewal form is true to the best of my knowledge, and I may be punished under law if I provide false or untrue information.

________________________________________________       ______________________________
Your signature                                                                       Today’s date

10. **Remember!** Make sure you answered all questions and signed the form.

    ➤ Send this form to us with all proofs by **February 25, 2014.**