

# BENEFIT CHOICE ELECTION FORM – PERIOD 1

May 1 – 31, 2008 (Changes effective July 1, 2008)

**COMPLETE THIS FORM ONLY TO MAKE A CHANGE IN YOUR BENEFITS**

**SECTION A: EMPLOYEE INFORMATION (required)**

SSN:           —           —

Last Name	First Name	Phone Numbers	
		Home: _____	Work: _____

**SECTION B: OPT OUT / OPT IN**

**OPT OUT/OPT IN of Health & Dental**

Opt Out     Opt In    See Section B of the Instruction Sheet on back for requirements

**SECTION C: HEALTH PLAN ELECTIONS (complete only if CHANGING your health plan)**

Health Plan Election *	If you selected Managed Care, <b>you must</b> complete the information below. Go to the health plan's website to find the provider identifier. See the Instruction Sheet on back for more information.
<b>Elect One:</b> Quality Care Health Plan (QCHP) <input type="checkbox"/> ~ Or ~ Managed Care (HMO or OAP) <input type="checkbox"/>	Provider Identifier _____ (6 or 10 characters) Carrier Code _____ (2 characters – see page 5) Plan Name _____

\* **You must** complete a Coordination of Benefits Worksheet for yourself and/or any dependent that has other insurance coverage (including Medicare or Medicaid). The Coordination of Benefits Worksheet is available at [www.benefitschoice.il.gov](http://www.benefitschoice.il.gov).

**SECTION D: DENTAL PLAN OPTION**

Dental Plan Option
I choose not to participate in the dental plan <input type="checkbox"/> I choose to re-enroll in the dental plan <input type="checkbox"/>

**SECTION E: OPTIONAL LIFE INSURANCE (complete only if CHANGING life coverage elections)**

OPTIONAL LIFE	<input type="checkbox"/> INCREASE <sup>2</sup> <input type="checkbox"/> DECREASE <input type="checkbox"/> CANCEL	AD&D (Accidental Death & Dismemberment)	
<input type="checkbox"/> 1 x Basic <input type="checkbox"/> 2 x Basic	<input type="checkbox"/> 3 x Basic <input type="checkbox"/> 4 x Basic	<input type="checkbox"/> 5 x Basic <input type="checkbox"/> 6 x Basic	<input type="checkbox"/> 7 x Basic <input type="checkbox"/> 8 x Basic
		<input type="checkbox"/> CANCEL AD&D	<input type="checkbox"/> BASIC only (Basic) <input type="checkbox"/> COMBINED (Basic + Optional Life)

**SECTION F: DEPENDENT INFORMATION <sup>1</sup> (dependents will be enrolled in the same health plan as the member)**

A (Add) / D (Drop) / C (Change)					Name	SSN	Birth Date	Relationship <sup>3</sup>	Provider Identifier
HEALTH			LIFE <sup>2</sup>						
A	D	C	A	D					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

- Notes:** <sup>1</sup> Documentation required to add dependents – see specific documentation requirements on the Instruction Sheet.  
<sup>2</sup> Statement of Health form required when increasing Optional Life or adding Spouse or Child Life (form available at [www.benefitschoice.il.gov](http://www.benefitschoice.il.gov)).  
<sup>3</sup> Relationship must be spouse, son, daughter, stepchild, adopted child, adjudicated child or legal guardian.

I authorize prevailing premiums to be deducted from my pay or annuity for those plans I have selected. This authorization will remain in effect until I provide written notice to the contrary. The information contained in this form is complete and true. I agree to abide by all Group Insurance Program rules. I agree to furnish additional information requested for enrollment or administration of the plan I have elected.

MEMBER SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
 GIR/GIP SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**Give completed form to your GIR by May 31, 2008.**

## BENEFIT CHOICE ELECTION FORM INSTRUCTION SHEET

*If you are keeping your current coverage elections you do **not** need to complete the Benefit Choice Election Form.*

### SECTION A – EMPLOYEE INFORMATION (Complete all fields)

### SECTION B – OPT OUT / OPT IN

If you wish to opt out of the State Employees Group Insurance Program you must complete the 'Opt Out/Opt In' portion of Section B and submit an 'Opt Out/Opt In Election Certificate' to your agency/university Group Insurance Representative (GIR). The form is available through your agency GIR or online at [www.benefitschoice.il.gov](http://www.benefitschoice.il.gov).

### SECTION C – HEALTH PLAN ELECTIONS

Do not complete this section if you only want to change your Primary Care Physician (PCP) – you must contact your managed care plan directly in order to make this change.

If you wish to change your **health** plan you must check either the Quality Care Health Plan (QCHP) or the managed care plan box. If **electing/changing managed care plans**, you must enter the managed care plan's carrier code (see map on page 5 for carrier codes), the plan's name and the provider identifier. The provider identifier is associated with a specific physician and is referenced as either the PCP code (6 characters) or NPI code (10 characters). Provider identifiers are located in the managed care plan's online directory, available on their website (see inside front cover of this booklet for website addresses).

### SECTION D – DENTAL PLAN OPTION

- If you are currently participating in the **dental** plan and wish not to participate in the upcoming plan year you must check the 'I choose not to participate in the dental plan' box (proof of other dental coverage is not required). If you elect not to participate, you can re-enroll **only** during a future Benefit Choice election period.
- If you **currently are not** participating in the **dental** plan and wish to re-enroll for the upcoming plan year you must check the 'I choose to re-enroll in the dental plan' box. Benefit Choice is the only time you can re-enroll in the dental plan.

### SECTION E – OPTIONAL LIFE INSURANCE

Complete this section if you wish to add/drop/increase or decrease Optional Life<sup>1</sup> or Accidental Death and Dismemberment (AD&D) coverage. **Note:** Optional Life Coverage subject to \$3,000,000 maximum (basic + optional life). AD&D Combined maximum is 5 times the employee salary (basic plus 4 times optional coverage).

### SECTION F – DEPENDENT INFORMATION

Complete this section if you are adding, dropping or changing your dependent health or life<sup>1</sup> coverage. If you are adding health or life dependent coverage, **you must provide the appropriate documentation as indicated below:**

Spouse	Marriage certificate
Natural Child through Age 18	Birth certificate
Stepchild	Birth certificate indicating your spouse is the child's parent, marriage certificate and proof the child resides with you at least 50% of the time.
Adopted Child	Adoption certificate stamped by the circuit clerk.
Adjudicated Child/Legal Guardian	Court documentation signed by a judge.
Student	Birth certificate, Dependent Coverage Certification Statement (CMS-138)*, and verification of full-time student enrollment in an accredited school.
Handicapped	Birth certificate, Dependent Coverage Certification Statement (CMS-138)*, and a letter from the doctor 1) detailing the dependent's limitations, capabilities and onset of condition from a cause originating prior to age 19 (age 23 if enrolled as a full-time student), 2) a diagnosis from a physician with an ICD-9 diagnosis code and 3) a statement from the Social Security Administration with the Social Security disability determination, along with a copy of the Medicare card.
* The Dependent Coverage Certification Statement (CMS-138) is available through your agency Group Insurance Representative (GIR) or online at <a href="http://www.benefitschoice.il.gov">www.benefitschoice.il.gov</a> .	

<sup>1</sup> If you are applying to add or increase Optional Life, Spouse Life or Child Life, you must complete, sign and mail a Statement of Health application to **Minnesota Life, 1 North Old Capitol Plaza, Suite 305, Springfield, IL 62701**. The Statement of Health application is available at [www.benefitschoice.il.gov](http://www.benefitschoice.il.gov) or through your agency GIR.

**SIGNATURE:** You must sign and date the Benefit Choice Election Form and give to your agency GIR by **May 31, 2008** in order for your elections to be effective July 1, 2008. Dependent documentation must be submitted to your GIR within 10 days of the end of the Benefit Choice Period. **If documentation is not provided within the 10-day period, your dependents will not be added.**