



# CIP - Instruction Sheet For Benefit Recipient Group Insurance Form

**Complete this form and mail to:**  
**State Universities Retirement System, P.O. Box 2710, Champaign, IL 61825-2710**

This form is used for initial enrollment into the program or to process changes requested during the annual Benefit Choice Period. For initial enrollment, the entire form must be completed. For enrollment during the Benefit Choice Period, only the appropriate carrier or dependent beneficiary information, if dependents are added, need to be completed. Enter complete name and social security number (SSN). Check the appropriate box for Initial Enrollment or Benefit Choice, or both if enrolling during Benefit Choice Period.

## SECTION I – Personal Information (please type or print clearly)

**Effective date of enrollment:** Enter the date coverage is effective (see the Benefits Handbook for coverage effective dates). Enrollments requested during the Benefit Choice Period will always be effective July 1. **Marital Status:** S=Single, M=Married. **Birthdate:** Enter two-digit month, two-digit day and four-digit year. Example: 07/28/1945. **Sex:** M=Male, F=Female.

## SECTION II – Medicare Status

**Medicare Status** – Check the box that correctly reflects your Medicare status.  
**Medicare Box 1** – You are under 65 years of age and ineligible for Medicare due to age.  
**Medicare Box 2, 4 or 5** – Provide specific Part A, Part B and/or Part D dates and indicate whether Part A of Medicare is free. A copy of your Medicare card(s) must accompany this form.  
**Medicare Box 3** – You are 65+ and ineligible for Medicare. A letter from Medicare stating ineligibility should accompany this form.

If you have **Medicare Part C**, indicate the type code from the following: **1. HMO 2. POS 3. PSO 4. PPO 5. Religious Fraternal Benefit Society Plan 6. Private Fee-for-Service Plan 7. Medical Savings Account (MSA) Plan**

## SECTION III – Address Information

**Benefit Recipient Residential Address:** Enter your address on the left side of this section.  
**Other Addressee:** If another person handles your personal affairs, complete the “Other Addressee” column. The relationship space should be filled with one of the following codes:  
**1. Custodial Parent 2. Trustee 3. Power-of-Attorney 4. Legal Guardian**  
**Date of Relationship:** Enter the date that the other addressee was effective. **Send Mail to this Address (Y/N):** You can choose to have mail sent to your other addressee by entering (Y) for yes in the “Send Mail to this Address” field. If you want mail sent to both addresses, enter (Y) for yes in both “Send Mail to this Address” fields.

## SECTION IV – Type of Enrollee

Check the box that reflects your appropriate eligibility status: **Benefit Recipient, Survivor of a Benefit Recipient, COBRA** (only applicable if you have had coverage under the College Insurance Program as a benefit recipient or a Dependent Beneficiary).  
**Reason for Enrollment:** This field should be completed with one of the following codes:  
**1. Application for Annuity 2. Benefit Recipient Turns 65 3. Coverage Terminated by Employer 4. Benefit Choice**  
Additional information on these four enrollment periods is located in the Benefits Handbook.  
**Type of Enrollee:** SURS Staff will complete this information.

## SECTION V – Survivor Information

If you are enrolling as a survivor, please complete this section.

## SECTION VI – Health Plan

If you are choosing: **College Choice Health Plan (CCHP)** check box 1, an **HMO or the OAP Plan**, check box 2. **If you checked box 2, please indicate the name of the plan and enter the plan carrier code (2 characters).** Carrier codes are listed on page 3. **Enter the provider identifier (6 or 10 characters),** which can be found in the managed care provider directory of your chosen plan.

## SECTION VII – Coordination of Benefits

If you are enrolled in another group health or dental plan, please complete the information requested in this section.