

**College Insurance Program
Dependent Beneficiary Group Insurance Form**



CIP Benefit Recipient Name _____ SSN: _____ - _____ - _____

Initial Enrollment **Benefit Choice** (July 1 effective date) Phone #: () _____ - _____

Complete this form if you are enrolling an eligible Dependent Beneficiary. If you need additional dependent forms, please contact SURS.

SECTION I Dependent's Personal Information: (Please print or type)

Dependent SSN: _____ - _____ - _____ Effective Date of Enrollment: _____ - _____ - _____
 Last Name _____ First _____ Middle _____
 Birthdate (mm/dd/ccyy): _____ - _____ - _____ Sex: (M/F) _____ Retirement Date (mm/dd/ccyy): _____ - _____ - _____

SECTION II Dependent's Medicare Status: (check one)

- | | |
|--|--|
| 1 Non-Medicare <input type="checkbox"/> | 3 Medicare Ineligible age 65+ <input type="checkbox"/> |
| 2 Medicare Eligible age 65+ <input type="checkbox"/> | 4 Medicare Disability <input type="checkbox"/> |
| | 5 End Stage Renal <input type="checkbox"/> |

Medicare Number: _____

If 2, 4 or 5 was checked, complete the following and submit a copy of the Medicare card:

- | |
|---|
| Part A (Begin Date) _____ - _____ - _____ |
| Part B (Begin Date) _____ - _____ - _____ |
| Part C (Begin Date) _____ - _____ - _____ |
| Part D (Begin Date) _____ - _____ - _____ |
| Part A Free (Y) ___ (N) ___ Part C Type Code: _____ |

SECTION III Dependent's Address Information:

Dependent Beneficiary Residential Address
(If different than Benefit Recipient)

 City: _____
 State: _____ ZIP Code: _____ + _____
 County of Residence: _____
 Country: _____
 (for foreign address only)
 Send Mail to this Address (Y/N): _____

Other Addressee Name and Address:
 Name: _____
 Address: _____
 City: _____
 State: _____ ZIP Code: _____ + _____
 Country: _____
 (for foreign address only)
 Addressee SSN: _____ - _____ - _____
 Relationship Code: _____
 Date of Relationship: _____ - _____ - _____
 Send Mail to this Address (Y/N): _____

SECTION IV Relationship: (Check One) Supporting documentation is required to add a dependent.

- | | | |
|--|---|--|
| 1 Spouse <input type="checkbox"/> | 4 Stepchild <input type="checkbox"/> | 7 Adjudicated Child <input type="checkbox"/> |
| 2 Natural Child <input type="checkbox"/> | 5 Recognized Child <input type="checkbox"/> | 8 Student <input type="checkbox"/> |
| 3 Adopted Child <input type="checkbox"/> | 6 Legal Guardian <input type="checkbox"/> | 9 Handicapped <input type="checkbox"/> |
| | | 10 Parent <input type="checkbox"/> |

Reason for Enrollment: _____

SECTION V Health Plan:
(Check plan of Benefit Recipient)

If choosing an HMO or the OAP plan, please provide the following:

- | | |
|--|----------------------------|
| College Choice Health Plan (CCHP) <input type="checkbox"/> | 1 <input type="checkbox"/> |
| HMO or OAP Plan <input type="checkbox"/> | 2 <input type="checkbox"/> |

Plan Name: _____
 Plan Carrier Code (2 characters): _____
 Provider Identifier (6 or 10 characters): _____

SECTION VI Coordination of Benefits:

If you are enrolled in another group health or dental plan, please complete the following:

| Health/Dental | Begin Date | Carrier Name |
|---------------|-----------------------|--------------|
| _____ | _____ - _____ - _____ | _____ |
| _____ | _____ - _____ - _____ | _____ |

The authorization for my Dependent Beneficiary coverage election is to remain in effect until I provide written notice to the contrary. The statement and answers contained in this application are complete and true. I agree to abide by all rules and to furnish any additional information requested. My signature below confirms that I understand all above options selected and authorize the release of information to the health plan I select and the State of Illinois.

CIP Benefit Recipient Signature: _____ Date: _____ - _____ - _____

(Signature required)

Instruction Sheet for Dependent Beneficiary College Insurance Program

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 of a Dependent Beneficiary into the program or to process changes requested during the annual Benefit Choice Period. For initial enrollment of the Dependent Beneficiary, the entire form must be completed. For the Benefit Choice Period, only the appropriate carrier or Dependent Beneficiary information, if dependents are added, need to be completed. Enter the name and social security number of the CIP participant (this is not the Dependent Beneficiary you are enrolling but the person receiving the annuity). Check the appropriate box of Initial Enrollment or Benefit Choice, or both if enrolling during Benefit Choice Period.

SECTION I - Dependent's Beneficiary Personal Information

Dependent SSN: Enter the dependent's nine-digit social security number. Effective date of enrollment: Enter the date coverage is effective (see the Benefits Handbook for coverage effective dates). Name: Enter the dependent's complete name. Birthdate: Enter two-digit month, two-digit day and four-digit year. Example: 07/28/1945. Sex: M=Male, F=Female. Retirement Date: If your dependent is retired from a place of employment, enter the retirement date.

SECTION II - Dependent's Medicare Status

Medicare Status - Check the box that correctly reflects the Dependent Beneficiary's Medicare status.
Medicare Box 1 - The Dependent Beneficiary is 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 the Medicare card(s) must accompany this form.
Medicare Box 3 - The Dependent Beneficiary is 65+ and ineligible for Medicare. A letter from Medicare stating the dependent's ineligibility should accompany this form.

If your dependent has 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 - Dependent's Address

Dependent Beneficiary Residential Address: Enter the Dependent Beneficiary's address only if it is different from the member's address. Other Addressee: If another person handles the Dependent Beneficiary's 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 dependent's relationship with 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 - Dependent's Relationship

Check the box that reflects the correct relationship of the Dependent Beneficiary to the participant receiving an annuity. Birth Certificates are required when adding a dependent. The dependent types indicated below require additional documentation.

- 4 - Stepchild: Written documentation from the Benefit Recipient that the child lives with them in a parent-child relationship.
 - 6 - Legal Guardian: A copy of the court decree establishing the Benefit Recipient as legal guardian for a child under 18 years of age.
 - 7 - Adjudicated Child: A copy of the court decree establishing the Benefit Recipient's financial responsibility for the child's health care.
 - 8 - Student: A Dependent Coverage Certification Statement (CMS-138) and verification of full-time student enrollment in an accredited school.
- Reason for Enrollment: This field should be completed with one of the following codes: 1. Benefit Recipient Application for Annuity 2. Dependent Beneficiary Turns 65 3. Coverage Terminated by Employer 4. Benefit Choice

SECTION V - Health Plan

Dependents must be enrolled in the same plan as the Benefit Recipient.

If you are choosing: College Choice Health Plan (CCHP) check box 1, an HMO or OAP, 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. *Enrolling in a health plan automatically enrolls you in the dental and vision plans.*

SECTION VI - Dependent Coordination of Benefits

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