

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 College Insurance Program (CIP) and to make changes during the annual Benefit Choice Period. For Benefit Choice Period changes, you need only complete the sections that have changes. If you are adding a dependent you will need to complete the Dependent Beneficiary Group Insurance Form. Be sure to provide your and your dependent's complete name and Social Security Number (SSN). If you are enrolling in CIP for the first time during the annual Benefit Choice Period, check the Initial Enrollment box and the Benefit Choice box. For initial enrollment in CIP outside the Benefit Choice Period, check the Initial Enrollment box and complete the entire form.

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 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 the Social Security Administration stating ineligibility should accompany this form.

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" section. The relationship space should be filled with one of the following:
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 the Dependent Beneficiary's 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:
1. Application for Annuity 2. Benefit Recipient Turns 65
3. Coverage Terminated by Employer 4. Benefit Choice

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; if you are choosing either 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.