

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

2 Medicare Eligible age 65+ Part A (Begin Date) _____ - _____ - _____

3 Medicare Ineligible age 65+ Part B (Begin Date) _____ - _____ - _____

4 Medicare Disability Part D (Begin Date) _____ - _____ - _____

5 End Stage Renal Disease Part A Free (Y) _____ (N) _____

Medicare Number: _____

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: _____
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 4 Stepchild 7 Adjudicated Child

2 Natural Child 5 Recognized Child 8 Student

3 Adopted Child 6 Legal Guardian 9 Handicapped

10 Parent

Reason for Enrollment: _____

SECTION V Health Plan:

(Check plan of Benefit Recipient)

College Choice Health Plan (CCHP)

HMO or OAP Plan

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

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 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. Be sure to provide your (the person receiving the annuity) and your dependent's complete name and Social Security Number (SSN). If you are enrolling a Dependent Beneficiary 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 - Dependent Beneficiary's Personal Information

Dependent SSN: Enter the Dependent Beneficiary's 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 Beneficiary'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 Beneficiary is retired, enter the retirement date.

SECTION II - Dependent Beneficiary'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 the Social Security Administration stating the Dependent Beneficiary's ineligibility should accompany this form.

SECTION III - Dependent Beneficiary'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" 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 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 Beneficiary'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, if you are choosing an HMO or the OAP Plan, check box 2. If you checked box 2, please indicate the name of the plan and the plan's 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 Beneficiary's Coordination of Benefits

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