



# 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 6. **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.

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) If 2, 4 or 5 was checked, complete the following and submit a copy of the Medicare card:  
 1 Non-Medicare  3 Medicare Ineligible age 65+  Part A (Begin Date) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 2 Medicare Eligible age 65+  4 Medicare Disability  Part B (Begin Date) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
5 End Stage Renal  Part C (Begin Date) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Medicare Number: \_\_\_\_\_ 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 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)  1   
 HMO or OAP Plan  2

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 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 6. **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.