

**LOCAL GOVERNMENT HEALTH PLAN (LGHP)**  
**BENEFIT CHOICE ELECTION FORM**  
 ENROLLMENT PERIOD: MAY 1 – MAY 31, 2009  
 Complete This Form Only If Changing Your Benefits

**SECTION A: EMPLOYEE INFORMATION (required)**

SSN:           —           —

Last Name	First Name	Phone Numbers	
		Home:	Work:

**SECTION B: HEALTH PLAN ELECTION (complete only if changing health plans)**

Health Plan Election *	If you selected Managed Care Plan, <u>you must</u> complete the information below. To find the provider identifier, go to the health plan's website. See the instructions on back for more information.
<b>Elect One:</b> Local Care Health Plan (LCHP) <input type="checkbox"/> <p style="text-align: center;">~ Or ~</p> Managed Care Plan (HMO or OAP) <input type="checkbox"/>	Provider Identifier _____ (6 or 10 characters) Carrier Code _____ (2 characters – see page 5) Plan Name _____

\* If you have another health insurance plan, including Medicare, you must give a copy of you and/or your dependent's other insurance card to your HPR. The copy must include the front and back of the card.

**SECTION C: DEPENDENT INFORMATION <sup>1</sup> (dependents will be enrolled with the same coverage that you have)**

NOTE: If you wish to add an adult child due to Public Act 95-0958, DO NOT ENTER YOUR DEPENDENT'S INFORMATION IN THIS SECTION. Instead, you must complete a Special Enrollment Period – Eligibility Certification Statement, available at [www.benefitschoice.il.gov](http://www.benefitschoice.il.gov).

HEALTH			Name	SSN	Birth Date	Relationship <sup>2</sup>	Sex (M/F)	Provider Identifier
A (Add) / D (Drop) / Change (C)								
A	D	C						

**Note:** <sup>1</sup> Documentation required to add dependents – see specific documentation requirements on the back.

<sup>2</sup> Relationship must be spouse, son, daughter, stepchild, adopted child, adjudicated child or legal guardian.

This authorization will remain in effect until I provide written notice to the contrary. The information contained in this form is complete and true. I agree to abide by all Local Government Health Plan rules. I agree to furnish additional information requested for enrollment or administration of the plan I have elected.

MEMBER SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

HPR SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**Give completed form to your unit's HPR by May 31, 2009.**

# BENEFIT CHOICE ELECTION FORM INSTRUCTION SHEET

*If you are keeping your current coverage elections you do **not** need to complete the Benefit Choice Election Form.*

## SECTION A – EMPLOYEE INFORMATION

Complete all fields.

## SECTION B – HEALTH PLAN ELECTION

*Do **not** complete this section if you only want to change your Primary Care Physician (PCP) – you must contact your managed care plan directly in order to make this change.*

If you wish to change your **health** plan you must check either the Local Care Health Plan (LCHP) or the Managed Care box. If **electing/changing managed care plans**, you must enter the managed care plan's carrier code (see page 5 for carrier codes), the plan's name and the provider identifier. The provider identifier is associated with a specific physician and is referenced as either the PCP code (6 characters) or NPI code (10 characters). Provider identifiers are located in the managed care plan's online directory, available on their website (see inside front cover for website addresses).

## SECTION C – DEPENDENT INFORMATION

Complete this section if you are adding or dropping health coverage for a dependent. If you are adding dependent health coverage, you must provide the appropriate documentation as indicated below.

**NOTE: If you wish to add an adult child due to Public Act 95-0958 DO NOT ENTER YOUR DEPENDENT'S INFORMATION IN THIS SECTION. Instead, you must complete a Special Enrollment Period – Eligibility Certification Statement, available at [www.benefitschoice.il.gov](http://www.benefitschoice.il.gov).**

Spouse	Marriage certificate
Natural Child through Age 18	Birth certificate
Stepchild	Birth certificate, marriage certificate indicating your spouse is the child's parent and proof the child resides with you at least 50% of the time.
Adopted Child	Adoption certificate stamped by the circuit clerk.
Adjudicated Child	Court documentation signed by a judge.
Student	Birth certificate, Dependent Coverage Certification Statement (CMS-138)* and verification of full-time student enrollment in an accredited school.
Handicapped	Birth certificate, Dependent Coverage Certification Statement (CMS-138)* and a letter from the doctor 1) detailing the dependent's limitations, capabilities and onset of condition from a cause originating prior to age 19, 2) a diagnosis from a physician with an ICD-9 diagnosis code and 3) a statement from the Social Security Administration with the Social Security disability determination, along with a copy of the Medicare card.
Other (dependent who has received an organ transplant after 6/30/2000)	Proof of transplant, Dependent Coverage Certification Statement (CMS-138)* <u>and</u> member's tax return or other documentation proving financial dependency.
* The Dependent Coverage Certification Statement (CMS-138) is available from your HPR.	

## SIGNATURE

You must sign and date the Benefit Choice Election Form and give to your HPR by **May 31, 2009** in order for your elections to be effective July 1, 2009. Dependent documentation must be submitted to your HPR within 10 days of the end of the Benefit Choice Period. **If documentation is not provided within the 10-day period, your dependents will not be added.**