

# BENEFIT CHOICE ELECTION FORM

Enrollment Period: May 1 – May 31, 2009  
Complete This Form Only If Changing Your Benefits

## SECTION A: MEMBER INFORMATION (required)

SSN: \_\_\_\_\_

Last Name	First Name	Phone Numbers	
		Home:	Work:

## SECTION B: OPT OUT / OPT IN (this election applies to your and your dependents' health, dental, vision and prescription coverage)

### OPT OUT/OPT IN –

Opt Out     Opt In    See instructions on the back for requirements

## SECTION C: HEALTH PLAN ELECTIONS (this election applies to your and your dependents' health coverage)

Health Plan Election *	If you selected Managed Care Plan, <b>you must</b> 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> Quality Care Health Plan (QCHP) <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 7) Plan Name _____

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

## SECTION D: DENTAL PLAN OPTION (this election applies to your and your dependents' dental coverage)

**Dental Plan Option** – If you elect not to participate in the Dental plan, your Dental coverage (and any dependent dental coverage) will be terminated (health, vision and prescription coverage will remain active)

I choose not to participate in the dental plan     I choose to enroll/re-enroll in the dental plan

## SECTION E: OPTIONAL LIFE INSURANCE (complete ONLY IF CHANGING your life coverage elections)

OPTIONAL LIFE <sup>1</sup>	<input type="checkbox"/> BASIC LIFE ONLY (free – equal to salary) <input type="checkbox"/> BASIC + OPTIONAL (select increment below)	AD&D (Accidental Death & Dismemberment)
<input type="checkbox"/> 1 x Salary <input type="checkbox"/> 3 x Salary <input type="checkbox"/> 5 x Salary <input type="checkbox"/> 7 x Salary <input type="checkbox"/> 2 x Salary <input type="checkbox"/> 4 x Salary <input type="checkbox"/> 6 x Salary <input type="checkbox"/> 8 x Salary		<input type="checkbox"/> NO AD&D <input type="checkbox"/> BASIC AD&D only (Equal to Salary) <input type="checkbox"/> AD&D COMBINED* (Basic Life + Optional Life) * AD&D COMBINED maximum is Basic + 4 times the Optional amount

## SECTION F: DEPENDENT INFORMATION <sup>2</sup> (dependents will be enrolled with the same health and dental 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			LIFE <sup>1</sup>			Name	SSN	Birth Date	Relationship <sup>3</sup>	Sex (M/F)	Provider Identifier
A (Add) / D (Drop) / Change (C)											
A	D	C	A	D	C						

**Note:** <sup>1</sup> Statement of Health form required when adding or increasing Optional Life or adding Spouse or Child Life.

Mail completed form to: **Minnesota Life, 1 North Old Capitol Plaza, Suite 305, Springfield, IL 62701.**

<sup>2</sup> Documentation required to add dependents – see specific documentation requirements on the back.

<sup>3</sup> Relationship must be spouse, son, daughter, stepchild, adopted child, adjudicated child or legal guardian.

I authorize premiums as established annually to be deducted from my pay for those plans I have selected. I understand that if my paycheck is insufficient or if I am not on payroll, I will be direct billed. I agree to abide by all Group Insurance Program rules. I agree to furnish additional information requested for enrollment or administration of the plan I have elected. I understand it is my responsibility to review my paycheck and verify the amounts of the insurance deductions are accurate and that if my deductions are not correct I must immediately contact my GIR. Falsification of the information contained on this form may result in discipline up to and including discharge.

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

GIR/GIP SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**Give completed form to your GIR in your Benefits Office by May 31, 2009**

# BENEFIT CHOICE ELECTION FORM INSTRUCTION SHEET

*If you are not changing you current coverage elections **DO NOT** complete this Benefit Choice Election Form*

## SECTION A – MEMBER INFORMATION (Complete all fields)

### SECTION B – OPT OUT OF/OPT INTO Health, Dental, Vision and Prescription Coverage

*Opting out will discontinue all health, dental, vision and prescription coverage; Opting in will establish health, dental, vision and prescription coverage. Whether you opt out or opt in, life coverage will not change.*

If you wish to OPT OUT of or OPT IN to the State Employees' Group Insurance Program you must mark the appropriate box in Section B and submit a completed Opt Out/Opt In Election Certificate (available on [www.benefitschoice.il.gov](http://www.benefitschoice.il.gov)). Elections to opt out also require proof of other health coverage (other coverage cannot be provided by Central Management Services). Submit the completed forms and documentation to your agency/university Group Insurance Representative (GIR).

### SECTION C – HEALTH PLAN ELECTIONS

*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 Quality Care Health Plan (QCHP) or the Managed Care Plan box. If **electing/changing managed care plans**, you must enter the managed care plan's carrier code (see map on page 7 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 the plan's website (see inside front cover of this booklet for website addresses).

### SECTION D – DENTAL PLAN OPTION

*This election applies to both the member's and their dependent's dental coverage.*

- If you **wish not to participate** in the dental plan, check the 'I choose not to participate in the dental plan' box. Proof of other dental coverage is not required. This election will remain in effect until you re-enroll. Re-enrollment is **only** allowed during a future Benefit Choice election period.
- If you **wish to enroll/re-enroll** in the dental plan, check the 'I choose to enroll/re-enroll in the dental plan' box. Benefit Choice is the only time you can enroll/re-enroll in the dental plan.

### SECTION E – OPTIONAL LIFE INSURANCE <sup>1</sup>

*Complete this section to add/drop/increase or decrease Optional Life or AD&D coverage. See Section F for Spouse and Child Life.*

**Note:** Optional Life coverage is subject to \$3,000,000 maximum (Basic Life + Optional Life).

### SECTION F – DEPENDENT INFORMATION <sup>1</sup>

*Complete this section if you are adding or dropping (1) dependent health/dental/vision coverage or (2) Spouse/Child Life coverage. If you are adding dependent 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 indicating your spouse is the child's parent, marriage certificate and proof the child resides with you at least 50% of the time.
Adopted Child	Adoption certificate stamped by the circuit clerk.
Adjudicated Child/Legal Guardian	Court documentation signed by a judge.
Student	Birth certificate, Dependent Coverage Certification Statement (CMS-138) <sup>2</sup> , and verification of full-time student enrollment in an accredited school.
Handicapped	Birth certificate, Dependent Coverage Certification Statement (CMS-138) <sup>2</sup> , 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 (age 23 if enrolled as a full-time student), 2) a diagnosis from a physician with an ICD-9 diagnosis code <u>and</u> 3) a statement from the Social Security Administration with the Social Security disability determination, along with a copy of the Medicare card.
<sup>1</sup> Adding and/or increasing Optional Life, Spouse Life or Child Life requires a signed Statement of Health application. <i>Mail the completed application to: Minnesota Life, 1 North Old Capitol Plaza, Suite 305, and Springfield, IL 62701.</i>	
<sup>2</sup> The Dependent Coverage Certification Statement (CMS-138) is available through your agency Group Insurance Representative (GIR) or online at <a href="http://www.benefitschoice.il.gov">www.benefitschoice.il.gov</a> .	

**SIGNATURE:** In order for your elections to be effective July 1, 2009, you must sign and date the Benefit Choice Election Form and submit it to your agency GIR by **May 31, 2009**. Dependent documentation must be submitted to your GIR 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.**