

LOCAL GOVERNMENT HEALTH PLAN (LGHP)
BENEFIT CHOICE ELECTION FORM
 (Instruction Sheet on Back)
 ENROLLMENT PERIOD: MAY 1 – MAY 31, 2010
 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 instruction sheet on back for more information.
Elect One: 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 map on 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 ¹ (dependents will be enrolled with the same coverage that you have)

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

Note: ¹ Documentation required to add dependents – see specific documentation requirements on the back.
² Relationship must be spouse, son, daughter, stepchild, adopted child, adjudicated child, legal guardianship, sponsored adult child or veteran adult child.

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, 2010.

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

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 map 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 (at least 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).

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.

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.

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 and Student Medical LOA	Birth certificate, Eligibility Certification Statement (CMS-138)* and documentation as indicated on the 'Documentation Requirements' page of the Eligibility Certification Statement.
Sponsored Adult Child	
Veteran Adult Child	
Handicapped	
Other (organ transplant recipient)	
* The Eligibility Certification Statement (CMS-138) is available on the Benefits Website at www.benefitschoice.il.gov .	

SIGNATURE

You must sign and date the Benefit Choice Election Form and give to your HPR by **May 31, 2010**, in order for your elections to be effective July 1, 2010. 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.**