

# FY2011 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: MEMBER INFORMATION (required)

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

Last Name	First Name	Phone Numbers	
		Home:	Work:

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

See instructions on the back for additional documentation requirements

<input type="checkbox"/> Opt Out/Waive Coverage if currently enrolled in the Program <input type="checkbox"/> Opt In or Elect Coverage if not currently enrolled	<input type="checkbox"/> Opt Out with Financial Incentive – only SERS Annuitants who are <b>not</b> eligible for Medicare can elect this option
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## SECTION C: HEALTH PLAN ELECTIONS (this election applies to your and your dependents' health coverage)

Health Plan Election *	If you selected Managed Care Plan, you <u>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> Quality Care Health Plan (QCHP) <input type="checkbox"/> <p style="text-align: center;">~ Or ~</p> Managed Care Plan (HMO or OAP) <input type="checkbox"/>	PCP/Provider Identifier _____ (6 - 10 characters) Carrier Code _____ (2 characters – see map) Carrier/Plan Name _____

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

## SECTION D: DENTAL PLAN OPTION (complete ONLY IF CHANGING your current dental coverage election)

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 <u>and</u> prescription coverage will remain active)	
<input type="checkbox"/> I am currently enrolled in the dental plan and would like to drop the dental coverage	<input type="checkbox"/> I am <b>not</b> currently enrolled in the dental plan and would like to elect the dental coverage

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

OPTIONAL LIFE <sup>1</sup>	BASIC LIFE ONLY (free – equal to salary)	AD&D (Accidental Death & Dismemberment)
	<input type="checkbox"/> BASIC + OPTIONAL (select increment below)	<input type="checkbox"/> NO AD&D <input type="checkbox"/> BASIC AD&D only (Equal to Salary)
<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"/> AD&D COMBINED* (Basic Life + Optional Life) * AD&D COMBINED maximum is Basic + 4 times Salary
Annuitants age 60 and over are not eligible for 5 – 8 times Salary		

## SECTION F: DEPENDENT INFORMATION <sup>2</sup> (will have the same health, vision, prescription and dental coverage as the member)

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. Form available online.  
<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, legal guardianship, sponsored or veteran adult child.

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, 2010**

# BENEFIT CHOICE ELECTION FORM INSTRUCTION SHEET

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

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

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

*Opting out or waiving coverage will discontinue all health, dental, vision and prescription coverage; Opting in will establish health, dental, vision and prescription coverage; however you may elect to waive the dental coverage at the time you opt into the health, vision and prescription coverage. Whether you opt out, waive or opt in, your life coverage elections will remain the same.*

- **Full-time employees, annuitants and survivors** may opt out of the coverage by submitting a completed Opt Out Election Certificate along with proof of other comprehensive health coverage (other coverage cannot be provided by Central Management Services).
- **Part-time employees, annuitants and survivors required to pay a percentage of the State's portion of the premium** may elect to waive the coverage without proof of other coverage.
- **Non-Medicare SERS annuitants** may be eligible to receive a \$150.00 financial incentive when they opt out of the State's coverage and provide proof of other comprehensive health coverage (other coverage cannot be provided by Central Management Services). Once you elect this option to opt out you will be mailed a packet by SERS. The packet will include additional required forms. Note: This option is NOT available for annuitants of SURS, TRS, GARS or JARS.
- The completed forms and documentation must be submitted to your Group Insurance Representative (GIR).

### SECTION C – HEALTH PLAN ELECTIONS

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 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 the plan's website (see inside front cover of this booklet 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 D – DENTAL PLAN OPTION

*Your election decision will apply to both your and your dependents' dental coverage.*

- If you are currently enrolled in the dental plan and **wish to drop the coverage**, check the appropriate box. This election will remain in effect until you re-elect the dental coverage, which is **only** allowed during a future Benefit Choice election period.
- If you are currently **not** enrolled in the dental plan and **wish to elect the coverage**, check the appropriate box. The Benefit Choice Period is the only time you can elect dental coverage if you previously dropped the coverage. Members must be enrolled in the health plan in order to elect this option.

### SECTION E – MEMBER OPTIONAL LIFE INSURANCE

*Complete this section to add/drop/increase or decrease Member Optional Life or AD&D coverage. **Note:** Life coverage is subject to a \$3,000,000 maximum (Basic Life + Optional Life). Adding and/or increasing Optional Life requires a signed Statement of Health application\* for the member. Annuitants age 60 and older are not eligible for 5 – 8 times of Optional Life coverage.*

### SECTION F – DEPENDENT INFORMATION

*Complete this section if you are adding or dropping (1) dependent health/dental/vision/prescription coverage or (2) Spouse/Child Life coverage. Adding Spouse Life and/or Child Life requires a signed Statement of Health application\* for that dependent. *If you are adding a dependent for the first time, you must provide your GIR/P with the appropriate documentation as indicated below:**

Spouse	Marriage certificate.
Natural Child through Age 18	Birth certificate.
Stepchild through Age 18	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 through Age 18	Adoption certificate stamped by the circuit clerk.
Adjudicated Child/Legal Guardianship through Age 18	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 (IRS/non-IRS)	
Handicapped	
Other (organ transplant recipient)	
* The Eligibility Certification Statement (CMS-138) and the Statement of Health application are available on the Benefits Website at <a href="http://www.benefitschoice.il.gov">www.benefitschoice.il.gov</a> .	

**SIGNATURE:** In order for your elections to be effective July 1, 2010, you must sign and date the Benefit Choice Election Form and submit it to your agency GIR by **May 31, 2010**. 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 dependent(s) will not be added.**