



## 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 College Insurance Program (CIP) and to enroll or make coverage changes during the annual Benefit Choice Period. For Benefit Choice Period changes, complete only the sections that have changes. Be sure to provide your complete name and Social Security Number (SSN). For initial enrollment in CIP outside the Benefit Choice Period, complete the entire form. If you are adding a dependent you will need to complete the Dependent Beneficiary Group Insurance Form.

Check the box for your reason/qualifying event for enrolling in CIP. If you are a Survivor, you must also supply the deceased member's SSN and check the box that indicates your relationship to the Benefit Recipient.

### 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 be effective July 1st. **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 the Social Security Administration stating Medicare ineligibility should accompany this form.

### 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" section.

The relationship space should be filled with one of the following:

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 – Health Plan

If you are choosing the **College Choice Health Plan (CCHP)**, check box 1; if you are choosing either an **HMO or the OAP Plan**, check box 2. **If you check box 2, please indicate the name of the plan and the plan's carrier code (2 characters).** Carrier codes are listed on the managed care plan map which can be found through the CIP link on the Benefits website at [www.benefitschoice.il.gov](http://www.benefitschoice.il.gov). **Enter the PCP number of provider identifier (6 - 10 characters)**, which can be found in the managed care provider directory of your chosen plan.

### SECTION V – Coordination of Benefits

If you are enrolled in another group health or dental plan, you must submit a copy of your health and/or dental card to your GIR.