

# LOCAL GOVERNMENT HEALTH PLAN (LGHP) BENEFIT CHOICE ELECTION FORM

(Instruction Sheet on Back)

Enrollment Period May 1, 2011 - June 20, 2011

**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)

<b>Health Plan Election *</b>  <i>Elect One:</i> Local Care Health Plan (LCHP) <input type="checkbox"/> <p style="text-align: center;">~ Or ~</p> Managed Care Plan (HMO or OAP) <input type="checkbox"/>	<b>If you selected an HMO or OAP plan, you must complete the following:</b> Carrier Code _____ (2 characters – see map) Carrier/Plan Name _____  <b>If you elected an HMO, also complete the field below</b> (to find the PCP/Provider Identifier, go to the health plan's website): PCP/Provider Identifier _____ (6 - 10 characters)
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\* 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)

HEALTH			Name	SSN (REQUIRED)	Birth Date	Relationship <sup>2</sup>	Sex (M/F)	HMO 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, legal guardianship or adult veteran 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.**

# 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 HMO or OAP plan's carrier code (see map for carrier codes) and the plan's name. If you are electing an HMO, you must also complete the PCP/Provider Identifier field. 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 of the Benefit Choice 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 C – DEPENDENT INFORMATION

**Complete this section if you are (1) changing your health plan to an HMO, or (2) adding or dropping dependent health coverage.** If your dependents are already enrolled in health and you are only changing your health plan to LCHP or one of the OAP plans you do not need to complete this section. If you are adding dependent health coverage, you must also provide the appropriate documentation as indicated below:

Spouse	Marriage certificate
Natural Child through age 25	Birth certificate
Stepchild through age 25	Birth certificate indicating your spouse is the child's parent and a marriage certificate indicating the child's parent is the member's spouse.
Adopted Child through age 25	Adoption certificate stamped by the circuit clerk.
Adjudicated Child/Legal Guardianship through age 25	Court documentation signed by a judge.
Adult Veteran Child through age 29	Birth certificate, Eligibility Certification Statement (CMS-138)* and documentation as indicated on the 'Documentation Requirements' page of the Eligibility Certification Statement.
Disabled	
Other (organ transplant recipient)	
* The Eligibility Certification Statement (CMS-138) is available on the Benefits website at <a href="http://www.benefitschoice.il.gov">www.benefitschoice.il.gov</a> .	

## SIGNATURE

You must sign and date the Benefit Choice Election Form and give to your HPR by June 20, 2011, in order for your elections to be effective July 1, 2011.

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.**