

College Insurance Program (CIP) Benefit Recipient Group Insurance Form



Benefit Recipient Name: _____ SSN _____ - _____ - _____
Last First Middle

Reason for Enrollment - check **one** of the following reasons: Phone # () _____ - _____

- Application for Annuity**
 Coverage Terminated by Employer
 Benefit Recipient Turns 65
 Benefit Recipient Becomes Eligible for Medicare
 Benefit Choice

If you are a Survivor, also complete the following: SSN of deceased member _____ - _____ - _____

Relationship to deceased member: Spouse/Civil Union Partner Child Parent

SECTION I Personal Information (Please print or type): Effective Date of Enrollment _____ - _____ - _____

Marital Status (S/M) _____ Birthdate (mm/dd/ccyy) _____ - _____ - _____ Sex (M/F) _____

SECTION II Medicare Status (check one):

- 1 Non-Medicare
 2 Medicare Eligible age 65+
 3 Medicare Ineligible age 65+
 4 Medicare Disability
 5 End Stage Renal Disease

If 2, 4 or 5 was checked, complete the following and submit a copy of your Medicare card(s):

Part A (Begin Date) _____ - _____ - _____

Part B (Begin Date) _____ - _____ - _____

Part D (Begin Date) _____ - _____ - _____

Medicare Number _____

Part A Free (Y) _____ (N) _____

SECTION III Address Information:

 City _____
 State _____ ZIP Code _____ + _____
 County of Residence _____
 Country _____
 (for foreign address only)

*Other Addressee Name and Address:

Name _____
 Address _____
 City _____
 State _____ ZIP Code _____ + _____
 Country _____
 (for foreign address only)

Send Mail to this Address (Y/N): _____

Addressee SSN _____ - _____ - _____

Relationship _____

Date of Relationship _____ - _____ - _____

Send Mail to this Address (Y/N) _____

* If you have a Power of Attorney, legal guardian, trustee or custodial parent, please complete the "Other Addressee" information. If you want mail sent to both addresses, put "Y" in both "Send Mail to this Address" spaces.

SECTION IV *Health Plan (check one):

- College Choice Health Plan (CCHP)
 HMO or OAP Plan

If you selected a managed care plan, you must complete the following:

Plan Name _____

Plan Carrier Code (2 characters - see map) _____

***Enrolling in a health plan automatically enrolls you in the dental and vision plans.**

If you elected HMO Illinois or Blue Advantage HMO, also complete the PCP/Provider Identifier below:

PCP/Provider Identifier (6 - 10 characters) _____

SECTION V Coordination of Benefits:

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

The authorization for my insurance elections is to remain in effect until I provide written notice to the contrary. The statement and answers contained in this application are complete and true. I agree to abide by all rules and to furnish any additional information requested. My signature confirms that I understand all above options selected and authorize the release of information to the health plan I select and the State of Illinois.

CIP Benefit Recipient Signature _____ Date _____ - _____ - _____

(Signature required)

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 you are requesting to change. Be sure to provide your complete name and social security number (SSN). For initial enrollment in CIP outside of the annual Benefit Choice Period, you must complete the entire form. If you are adding a dependent you will also 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 (SSA) 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 an 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. **If you are enrolling in either HMO Illinois or Blue Advantage HMO, you must also enter the PCP number or 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 SURS.