CMS ILLINOIS DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

College Insurance Program (CIP)
Benefit Recipient Group Insurance Form

SURS

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

Initial Enrollment ☐ **Benefit Choice** (July 1 effective date) ☐

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 ☐

Medicare Number: _____

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 C (Begin Date) _____-_____-_____
Part A Free (Y)___(N) ___ Part C Type Code:____

SECTION III Address Information:

Benefit Recipient Residential Address

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

*Other Addressee Name and Address:
Name: _____
Address: _____
City: _____
State: _____ ZIP Code _____ +_____
Country: _____
(for foreign address only)
Addressee SSN: _____ - _____ - _____
Relationship Code:_____
Date of Relationship: _____-_____-_____
Send Mail to this Address (Y/N): _____

SECTION IV Type of Enrollee: (Check One)

Benefit Recipient ☐ Survivor ☐ COBRA ☐

Reason for Enrollment: ____

To be completed by SURS office staff
Type of Enrollee:_____ _____ _____ _____

SECTION V If you are a survivor, complete this Section:

SSN of deceased member: ____-___-_____ Relationship to Deceased Member: Spouse/Child/Parent _____

SECTION VI *Health Plan: (Check One)

College Choice Health Plan (CCHP) 1 ☐
HMO or OAP Plan 2 ☐

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

If you are choosing an HMO or OAP Plan, please provide the following:

Plan Name: _____
Plan Code: _____
Primary Care Provider #: _____

SECTION VII Coordination of Benefits:

If you are enrolled in another group health or dental plan, please complete the following:

Health/Dental	Begin Date	Plan Name
_____	_____ - _____ - _____	_____
_____	_____ - _____ - _____	_____

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 program, or to process changes requested during the annual Benefit Choice Period. For initial enrollment, the entire form is to be completed. For Benefit Choice Period, only the appropriate carrier information or the dependent beneficiary information, if dependents are added, needs to be completed. Enter complete name and social security number (SSN). Check the appropriate box for initial enrollment or Benefit Choice, or both if enrolling during Benefit Choice Period.

SECTION I – Personal Information. Please type or print clearly.

Effective date of enrollment: Enter the date that coverage is effective. Please see the column entitled, "When will my coverage be effective?" located on page 1 of the Member Handbook. Enrollments requested during the Benefit Choice Period will always be effective July 1. **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 and Part B 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 Medicare stating ineligibility should accompany this form.

If you have **Medicare Part C**, indicate the type code from the following: **1. HMO 2. POS 3. PSO 4. PPO 5. Religious Fraternal Benefit Society Plan 6. Private Fee-for-Service Plan 7. Medical Savings Account (MSA) Plan.**

SECTION III – Address Information

Benefit Recipient Residential Address: Enter your address on the left-hand side of this section.
Other Addressee: If another person handles your personal affairs, complete the "Other Addressee" column.
The relationship space should be filled with one of the following codes:
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" space. If you want mail sent to both addresses, enter (Y) for yes in both "Send Mail to this Address" spaces.

SECTION IV – Type of Enrollee

Check the box that reflects your appropriate eligibility status: **Benefit Recipient, Survivor of a Benefit Recipient, COBRA** (only applicable if you have had coverage under the College Insurance Program as a benefit recipient, or a dependent beneficiary).
Reason for Enrollment: This space should be completed with one of the following codes:
1. Application for Annuity 2. Benefit Recipient Turns 65 3. Coverage Terminated by Employer 4. Benefit Choice
Additional information on these four enrollment periods is located on page 1 of the Member Handbook.
Type of Enrollee: SURS Staff will complete this information.

SECTION V – Survivor Information

If you are enrolling as a survivor, please complete this section.

SECTION VI – Health Plan

If you are choosing: **College Choice Health Plan (CCHP) check box 1**; an **HMO or OAP Plan, check box 2. If you checked box 2, please indicate the name of the plan and enter the plan code.** The plan codes are listed in the Benefit Choice Booklet on page 14. **Enter the primary care provider's six-digit number**, which can be found in the managed care provider directory of your chosen plan.

SECTION VII – Coordination of Benefits

If you are enrolled in another group health or dental plan, please complete the information requested in this section.