

**College Insurance Program  
Dependent Beneficiary Group Insurance Form**



Complete this form if you are enrolling an eligible Dependent Beneficiary. If you need additional dependent forms, please contact SURS.

CIP Benefit Recipient Name \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Phone # ( ) \_\_\_\_\_ - \_\_\_\_\_

**SECTION I** Dependent's Personal Information (Please print or type):

Dependent SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Effective Date of Enrollment \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_  
Birthdate (mm/dd/ccyy) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex (M/F) \_\_\_\_\_ Retirement Date (mm/dd/ccyy) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**SECTION II** Dependent's 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) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Part A Free (Y) \_\_\_\_\_ (N) \_\_\_\_\_

Medicare Number \_\_\_\_\_

**SECTION III** Dependent's Address Information:

Dependent Beneficiary Residential Address  
(If different than Benefit Recipient)  
\_\_\_\_\_  
\_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ ZIP Code \_\_\_\_\_ + \_\_\_\_\_  
County of Residence \_\_\_\_\_  
Country \_\_\_\_\_  
(for foreign address only)  
Send Mail to this Address (Y/N) \_\_\_\_\_

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

**SECTION IV** Relationship (Check One): Supporting documentation is required to add a dependent (see instructions on back).

- |   |   |
|---|---|
| 1 Spouse <input type="checkbox"/>           | 7 Adjudicated Child <input type="checkbox"/>      |
| 2 Natural Child <input type="checkbox"/>    | 9 Disabled <input type="checkbox"/>               |
| 3 Adopted Child <input type="checkbox"/>    | 10 Parent <input type="checkbox"/>                |
| 4 Stepchild <input type="checkbox"/>        | 11 Sponsored Adult Child <input type="checkbox"/> |
| 5 Recognized Child <input type="checkbox"/> | 13 Veteran Adult Child <input type="checkbox"/>   |
| 6 Legal Guardian <input type="checkbox"/>   |   |

**Reason for Enrollment** (check one)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Benefit Recipient Application for Annuity | <input type="checkbox"/> Dependent Beneficiary Turns 65              | <input type="checkbox"/> Benefit Choice |
| <input type="checkbox"/> Coverage Terminated by Employer           | <input type="checkbox"/> Dependent Beneficiary Eligible for Medicare |   |

**SECTION V** Health Plan:

(Check plan of Benefit Recipient)  
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) \_\_\_\_\_

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

PCP/Provider Identifier (6 - 10 characters) \_\_\_\_\_

**SECTION VI** 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 Dependent Beneficiary coverage election 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 below 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)**

# Instruction Sheet for Dependent Beneficiary College Insurance Program

## Complete this form and mail to:

**State Universities Retirement System, P.O. Box 2710, Champaign, IL 61825-2710**

This form is used for the initial enrollment of a Dependent Beneficiary into the College Insurance Program (CIP) and to enroll or make coverage changes during the annual Benefit Choice Period. For initial enrollment outside the Benefit Choice Period, you must complete the entire form. For Benefit Choice Period changes, complete only the sections that you are requesting to change. Be sure to provide your (i.e., the person receiving the annuity) complete name and social security number (SSN).

### SECTION I - Dependent Beneficiary's Personal Information

**Dependent SSN:** Enter the Dependent Beneficiary's social security number. **Effective date of enrollment:** Enter the date coverage is effective (see the Benefits Handbook for coverage effective dates). **Name:** Enter the Dependent Beneficiary's complete name. **Birthdate:** Enter two-digit month, two-digit day and four-digit year. Example: 07/28/1945 **Sex:** M=Male, F=Female  
**Retirement Date:** If your Dependent Beneficiary is retired, enter the retirement date.

### SECTION II - Dependent Beneficiary's Medicare Status

**Medicare Status** - Check the box that correctly reflects the Dependent Beneficiary's Medicare status.

**Medicare Box 1** - The Dependent Beneficiary is 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 the Medicare card(s) must accompany this form.

**Medicare Box 3** - The Dependent Beneficiary is 65+ and ineligible for Medicare. A letter from the Social Security Administration (SSA) stating the Dependent Beneficiary's ineligibility should accompany this form.

### SECTION III - Dependent Beneficiary's Address

**Dependent Beneficiary Residential Address:** Enter the Dependent Beneficiary's address only if it is different from the member's address. **Other Addressee:** If another person handles the Dependent Beneficiary's 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 dependent's relationship with 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 - Dependent Beneficiary's Relationship

Check the box that reflects the relationship of the Dependent Beneficiary to the Benefit Recipient. Birth certificates and the dependent's SSN are required to add a dependent. The dependent types indicated below require additional documentation:

- 4 Stepchild/Child of Civil Union Partner:** Marriage certificate indicating that the member is married to, or in a civil union partnership with, the child's parent.
- 6 Legal Guardian:** A copy of the court decree establishing the Benefit Recipient as legal guardian for a child under 18 years of age.
- 7 Adjudicated Child:** A copy of the court decree establishing the Benefit Recipient's financial responsibility for the child's healthcare.
- 13 Veteran Adult Child:** Proof of Illinois residency and a Veterans' Affairs Release Form (DD-214) stating the date the adult child was released from service (or equivalent).

Check the box that reflects the reason for enrolling your dependent.

### SECTION V - Health Plan

**Dependents must be enrolled in the same plan as the Benefit Recipient.** If you are choosing the **College Choice Health Plan (CCHP)**, check box 1; if you are choosing 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](http://www.benefitschoice.il.gov). **If you are enrolling your dependent in either HMO Illinois or Blue Advantage HMO, enter the PCP number or provider identifier (6 - 10 characters),** which can be found in the managed care provider directory of your chosen plan. *Enrolling in a health plan automatically enrolls your dependent in the dental and vision plans.*

### SECTION VI - Dependent Beneficiary's Coordination of Benefits

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