CMS ILLINOIS DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

# College Insurance Program (CIP)
# Benefit Recipient Group Insurance Form

SURS

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

Email _____ Phone # ( ) _____-_____

**Reason for Enrollment** - check **one** of the following reasons: Effective Date of Enrollment _____-_____-_____

☐ **Application for Annuity** ☐ **Coverage Terminated by Employer** ☐ **Benefit Recipient Turns 65**

☐ **Benefit Recipient Becomes Eligible for Medicare** ☐ **Benefit Choice**

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

## SECTION I

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

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

## 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 ☐

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 D (Begin Date) _____-_____-_____
Part A Free (Y)_____(N) _____

## SECTION III Address Information:

_____
_____
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 _____
Date of Relationship _____-_____-_____
Send Mail to this Address (Y/N) _____

## SECTION IV *Health Plan (check one):

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

**If enrolling in HMO Illinois or BlueAdvantage HMO, enter the 3-digit medical group number:** _____

**If you elected a managed care plan, enter the plan name and 2-digit code:**

Plan Name _____ Plan Code** ____ (2 characters)
** see map of Illinois in Benefit Choice Options booklet for plan codes.

**If you elected an HMO, enter the 10-digit NPI (National Provider Identifier):**

National Provider Identifier _____

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

## 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.

**Reason for Enrollment:** Check the box for your reason/qualifying event for enrolling in CIP.
**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 I – Survivor Information (please type or print clearly)

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 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 an HMO, you must also enter the National Provider Identifier (NPI) number (10 digits)**, which can be found in the managed care provider directory of your chosen plan. If enrolling in either HMO Illinois or BlueAdvantage HMO, you should also enter the 3-digit medical group number which can be found on the plan administrator's provider listing page of their website.

## 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.