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 – MEMBER INFORMATION

Complete all fields.

SECTION B – HEALTH PLAN ELECTION

If you wish to **change your health** plan you must check the Local Care Health Plan (LCHP), the Local Consumer-Driven Health Plan (LCDHP), the OAP or the HMO box. If **electing/changing to either an HMO or OAP plan,** you must specify the plan's full name. If you are electing an HMO, you must also enter the National Provider Identifier (NPI) associated with your Primary Care Physician (PCP)*. NPI's are located in the HMO plan's online directory (available on the plan administrator's website) and are 10 digits in length. If you elect HMO Illinois or BlueAdvantage HMO you will also need to enter the 3-digit medical group number.

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 dependent(s) are already enrolled and you are only changing your health plan to LCHP, LCDHP 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 or Civil Union Partner	Marriage certificate or civil union partnership certificate
Natural Child through age 25	Birth certificate
Stepchild or civil union partner's child through age 25	Birth certificate indicating your spouse/civil union partner is the child's parent and a marriage/civil union partnership certificate indicating the child's parent is your spouse/civil union partner
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 (IRS/non-IRS) through age 29	Birth certificate (if not already on file), proof of Illinois residency and Veterans' Affairs release form DD-214 (or equivalent)
Disabled age 26 or older	Birth certificate (if not already on file), statement from the Social Security Administration with the Social Security disability determination or a court order adjudicating the disability, and a copy of the Medicare card (if applicable)
Other (organ transplant recipient)	Birth certificate (if not already on file), proof of organ transplant performed after June 30, 2000

Dependent documentation must be submitted to your HPR by the end of the Benefit Choice Period. **If documentation is not provided within the Benefit Choice Period, your dependents will not be added.**

SIGNATURE

You must sign and date the Benefit Choice Election Form and give to your HPR no later than **June 2, 2025,** in order for your elections to be effective July 1, 2025.

*A Primary Care Physician (PCP) is a family practice, general practice, internal medicine, pediatrician (children) or an OB/GYN (women) physician.

LOCAL GOVERNMENT HEALTH PLAN (LGHP)

BENEFIT CHOICE ELECTION FORM

Enrollment Period May 1 through June 2, 2025

Complete This Form Only If Changing Your Benefits

SECTION A: MEMBER INFORMATION

Last Name:	First Name:
Primary Phone #:	Alternate Phone #:
Email Address:	SSN:

SECTION B: HEALTH PLAN ELECTION (complete only if changing health plans)

Health Plan Election*

Elect One:

- ☐ Local Care Health Plan (LCHP)
- ☐ Local Consumer-Driven Health Plan (LCDHP)
- ☐ Health Maintenance Organization (HMO)
  - ☐ Aetna HMO
  - ☐ BlueAdvantage HMO
  - ☐ HMO Illinois
- ☐ Open Access Plan (OAP)
  - ☐ Aetna OAP
  - ☐ Blue Cross Blue Shield OAP
  - ☐ HealthLink OAP

If you selected an HMO or an OAP, you must complete the following:

Carrier Name: _____

If you elected an HMO, also complete the field below:

Nation Provider Identifier (NPI) (10 digits required):

_____

(NPI's can be found on the health plan's website)

If you elected HMO Illinois or BlueAdvantage HMO, you must complete the following:

Medical Group # (3 digits): _____

* If you have another health insurance plan, including Medicare, you must send a copy of your 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[1] (dependents will be enrolled with the same coverage that you have)

HEALTH A (Add) D (Drop) C (Change)			Name	SSN (REQUIRED)	Birth Date	Relationship[2]	Sex (M/F)	National Provider Identifier (HMOs only) If HMO IL or BlueAdvantage HMO add 3-digit Medical Group # °	Medical Group Number
A	D	C							

Note: [1]Documentation required to add dependents – see specific documentation requirements on the instruction sheet.

[2]Relationship categories are on the instruction sheet

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: _____

Send completed form to your unit's HPR no later than June 2, 2025.