FY 2013 BENEFIT CHOICE ELECTION FORM

Enrollment Period May 1, 2012 through June 15, 2012 – Effective July 1, 2012

Complete This Form Only If Changing Your Benefits

SECTION A: MEMBER INFORMATION (required)

Last Name	First Name	Phone Numbers	
		Primary:	Alternate:
Email Address:		SSN: — —	

SECTION B: OPT OUT/WAIVE or OPT IN (applies to you and your dependents' health, dental, vision and prescription coverage)

See the instruction sheet for additional documentation requirements

- ☐ Opt Out/Waive Coverage if currently enrolled in the Program
- ☐ Opt In or Elect Coverage if not currently enrolled
- ☐ Opt Out with Financial Incentive – only SERS Annuitants who are **not** eligible for Medicare can elect this option

SECTION C: HEALTH PLAN ELECTIONS (this election applies to your and your dependents' health coverage)

Health Plan Election *

Elect One:

- ☐ Quality Care Health Plan (QCHP)
- ☐ Open Access Plan (OAP)
- ☐ Health Maintenance Organization (HMO)

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

Carrier Name: _____ Carrier 2-digit code: _____

Medical Group # (3 digits) _____ (**Required for HMO Illinois and BlueAdvantage HMO only**)

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

National Provider Identifier (10 digits) _____

(National Provider Identifier can be found on the health plan's website)

* If you have another health insurance plan, including Medicare, you must give a copy of your and/or your dependents' other insurance card to your GIR. The copy must include the front and back of the card.

SECTION D: DENTAL PLAN OPTION (complete ONLY IF CHANGING your current dental coverage election)

Dental Plan Option – If you elect not to participate in the dental plan, your dental coverage (and any dependent dental coverage) will be terminated (health, vision and prescription coverage will remain active). You may change your dental election only during the Benefit Choice Period.

- ☐ I am currently enrolled in the dental plan and would like to drop the dental coverage (all other coverage remains in force).
- ☐ I am **not** currently enrolled in the dental plan and would like to elect the dental coverage

SECTION E: MEMBER OPTIONAL LIFE INSURANCE (complete ONLY IF CHANGING your life coverage elections)

OPTIONAL LIFE [1]

- ☐ BASIC LIFE ONLY (free – equal to salary)
- ☐ BASIC + OPTIONAL (select increment below)
  - ☐ Increase Optional or ☐ Decrease Optional

☐ 1 x Salary	☐ 3 x Salary	☐ 5 x Salary	☐ 7 x Salary
☐ 2 x Salary	☐ 4 x Salary	☐ 6 x Salary	☐ 8 x Salary

Annuitants age 60 and over are not eligible for 5 – 8 times Salary

AD&D (Accidental Death & Dismemberment)

- ☐ NO AD&D
- ☐ BASIC AD&D only (Equal to Salary)
- ☐ AD&D COMBINED* (Basic Life + Optional Life)

* AD&D COMBINED maximum is Basic + 4 times Salary

SECTION F: DEPENDENT INFORMATION [2] (will have the same health, vision, prescription and dental coverage as the member)

HEALTH (A (Add) / D (Drop) / C (Change))			LIFE [1]		Name	SSN (REQUIRED)	Birth Date	Relationship [3]	Sex (M/F)	National Provider Identifier (HMOs only) If HMO IL or BlueAdvantage add 3-digit Medical Group # ⇨	Medical Group Number
A	D	C	A	D							
☐	☐	☐	☐	☐							
☐	☐	☐	☐	☐							
☐	☐	☐	☐	☐							

Note: [1] Statement of Health form required when adding or increasing Member Optional Life or adding Spouse/Child Life. Form available online.
[2] Documentation required to add dependents – see specific documentation requirements on instruction sheet.
[3] Relationship categories are on the instruction sheet.

I authorize premiums as established annually to be deducted from my pay for those plans I have selected. I understand that if my paycheck is insufficient or if I am not on payroll, I will be direct billed. I agree to abide by all Group Insurance Program rules. I agree to furnish additional information requested for enrollment or administration of the plan I have elected. I understand it is my responsibility to review my paycheck and verify the amounts of the insurance deductions are accurate and that if my deductions are not correct I must immediately contact my GIR. Falsification of the information contained on this form may result in discipline up to and including discharge.

MEMBER SIGNATURE: _____ DATE: _____

GIR/GIP SIGNATURE: _____ DATE: _____

Give completed form to your GIR in your Benefits Office no later than June 15, 2012!

BENEFIT CHOICE ELECTION FORM
INSTRUCTION SHEET

*If you are not changing your current coverage elections **DO NOT** complete this Benefit Choice Election Form*

SECTION A – MEMBER INFORMATION (Complete all fields)

SECTION B – OPT OUT/WAIVE or OPT INTO Health, Dental, Vision and Prescription Coverage
Opting out and waiving coverage will discontinue all health, dental, vision and prescription coverage; Opting in will establish health, dental, vision and prescription coverage. If you elect to opt into the health, vision and prescription coverage, but do not want dental, you may waive the dental coverage (note: you may waive dental coverage only during the annual Benefit Choice Period). Whether you opt out, waive or opt in, your life coverage elections will remain the same.

- ***Full-time employees, annuitants and survivors*** may opt out of the coverage by submitting a completed Opt Out Election Certificate along with proof of other comprehensive health coverage (other coverage cannot be provided by Central Management Services).
- ***Part-time employees, annuitants and survivors*** may elect to waive the coverage without proof of other coverage. Part-time employees must complete the Part-time Employee Election/Waiver of Group Insurance Participation Form in addition to the Benefit Choice Election Form.
- ***Non-Medicare SERS annuitants*** may be eligible to receive a monthly financial incentive of $150.00 if they opt out of the State's coverage and provide proof of other comprehensive health coverage (other coverage cannot be provided by Central Management Services). Contact SERS for an opt-out packet if you would like to elect this option. The packet will include additional required forms. Note: This option is NOT available for annuitants of SURS, TRS, GARS or JRS.

The completed forms and documentation must be submitted to your Group Insurance Representative (GIR).

SECTION C – HEALTH PLAN ELECTIONS
If you wish to **change your health** plan you must check the Quality Care Health Plan (QCHP), the OAP or the HMO box. If **electing/ changing to either an HMO or OAP plan**, you must enter the HMO or OAP's carrier code (see map for carrier codes) and the plan's name. If you are electing an HMO, you must also enter the National Provider Identifier (NPI) associated with your Primary Care Physician (PCP)*. National Provider Identifiers are located in the HMO plan's online directory (available on the plan's website) and are 10 digits in length. If you elect HMO Illinois or BlueAdvantage HMO you will need to enter the 3-digit medical group number as well.

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 D – DENTAL PLAN OPTION
Your election decision will apply to both your and your dependents' dental coverage.

- If you are currently enrolled in the dental plan and **wish to drop the coverage**, check the appropriate box. This election will remain in effect until you re-elect the dental coverage, which is **only** allowed during a future Benefit Choice election period.
- If you are currently **not** enrolled in the dental plan and **wish to elect the coverage**, check the appropriate box. The Benefit Choice Period is the only time you can elect dental coverage if you previously dropped the coverage. Members must be enrolled in the health plan in order to elect this option.

SECTION E – MEMBER OPTIONAL LIFE INSURANCE
Complete this section to add/drop/increase or decrease Member Optional Life or AD&D coverage. **Note:** Life coverage is subject to a $3,000,000 maximum (Basic Life + Member Optional Life). Adding and/or increasing Member Optional Life requires a signed Statement of Health application*. Annuitants age 60 and older are not eligible for 5 – 8 times of Member Optional Life coverage.

SECTION F – DEPENDENT INFORMATION – *Complete this section if you are (1) changing your health plan to an HMO, or (2) adding or dropping either dependent health/dental/vision/prescription coverage or Spouse/Child Life coverage.* **If your dependents are already enrolled and you are only changing your health plan to QCHP or one of the OAP plans you do not need to complete this section.** Adding Spouse Life and/or Child Life requires a signed statement of health application. If you are adding a dependent for the first time, you must provide your GIR/P with 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), Eligibility Certification Statement (CMS-138)* and documentation as indicated on the 'Documentation Requirements' page of the Eligibility Certification Statement.
Disabled	
Other (organ transplant recipient)	

* The Eligibility Certification Statement (CMS-138) and the Statement of Health application are available on the Benefits website at **www.benefitschoice.il.gov**.

SIGNATURE: In order for your elections to be effective July 1, 2012, you must sign and date the Benefit Choice Election Form and submit it to your agency GIR no later than **June 15, 2012.** Dependent documentation must be submitted to your GIR within 10 days of the end of the Benefit Choice Period. **If documentation is not provided within the 10-day period, your dependent(s) will not be added.**

* A primary care physician (PCP) can be a family practice, general practice, internal medicine, pediatric or an OB/GYN physician.