CMS ILLINOIS DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

OPT OUT Election Certificate

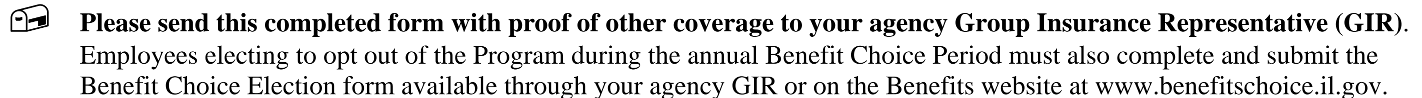
In accordance with Public Act 92-0600, State of Illinois full-time employees, retirees/annuitants and survivors may elect not to participate in the health, prescription dental and vision coverage of the State of Illinois Group Insurance Program (Program). By opting out, the Member and any enrolled dependents will have ALL coverage, except life coverage, terminated. Enrolled dependents of individuals electing to opt out will have the same coverage termination effective date as the Member.

Member Name:___________________________________ **Member SSN:**________________________________

I fully understand and certify the following:

1. The election to opt out of the Program is entirely voluntary. If I elect to opt out, any dependent coverage will also be terminated. The State of Illinois is not responsible for any expenses incurred, for myself or my dependents, on or after my termination date. Furthermore, my covered dependents and I are not eligible for COBRA continuation coverage.
2. I must complete this Opt Out Election Certificate and furnish proof of enrollment in another health benefit plan, either comprehensive major medical or comprehensive managed care, from a source other than the Illinois Department of Central Management Services (Department) including the Local Government Health Plan, Teachers' Retirement Insurance Program or College Insurance Program before my coverage will be terminated. My Program coverage will not be terminated until other eligible coverage is in effect, appropriate documentation has been submitted and such documentation has been approved by the Department. The effective date of opt out is at the discretion of the Department and must comply with Program requirements regarding opt out.
3. I may opt out of the Program only during the annual Benefit Choice period or within 60 days of an eligible Qualifying Change in Status.
4. If my spouse is a Member of any plan administered by the Department including the State of Illinois Group Insurance Program, Local Government Health Plan, Teachers' Retirement Insurance Program or College Insurance Program, I may not enroll as a dependent of my spouse in that plan.
5. If I elect to opt out of the Program, I will continue to be enrolled in the state-paid basic life insurance plan. I understand I am eligible to participate in the optional life insurance plan.
6. At a later date, if I wish to re-enroll in one of the health plans administered by the Department, I understand pre-existing condition limitations may apply if I am unable to provide a Certificate of Creditable Coverage from my previous insurance carrier that reflects that there has been no break in coverage greater than 63 days.
7. To the best of my knowledge, the documentation furnished to substantiate coverage in another health benefit plan is accurate and the policy is currently (or will be, prior to my termination) in force.

Member Signature:____ **Date:** _____/_____/_____



Please send this completed form with proof of other coverage to your agency Group Insurance Representative (GIR). Employees electing to opt out of the Program during the annual Benefit Choice Period must also complete and submit the Benefit Choice Election form available through your agency GIR or on the Benefits website at www.benefitschoice.il.gov.

GIR/P Use Only

Proof of comprehensive coverage attached? ☐

Check the appropriate Opt Out eligibility period:

☐ Benefit Choice

☐ Initial Enrollment - attach completed Group Insurance Enrollment/Change form (CMS-315)

☐ Qualifying Change in Status*; Reason Code:________

* ***Valid Qualifying Changes in Status and corresponding Reason Codes are:***

Marriage (32)
Change from PT to FT (63)
Spouse Gains Employment (62)
Retirement (63)
Return from/Entering into Non-pay Status (63)
Spouse now provided with Group Insurance coverage (46)
Medicare or Medicaid Eligibility Gained (64)
Coordination of Spouse's Election Period (47)
Member Becomes Eligible for Non-State Group Insurance Coverage (65)

____
Group Insurance Representative Signature/Date

____
Telephone Number

____
Agency Name

____
Organizational Processing Code

Coverage Documentation Submitted: ☐ Approved ☐ Denied

Opt Out Effective Date: _________________________