State of Illinois
Department of Central Management Services

Discrepancy Notification

ALL FIELDS MUST BE COMPLETED IN THIS SECTION

Date: 08/02/2026

Member Name: _____ Agency Name: _____

SSN: jnliandvjkn GIR Name: _____

GIR E-mail: _____ GIR Phone: _____

Org Proc: _____

Requesting: (Mark Only One)

- ☐ Delay Termination for CFT (Candidate for Termination) Member
- ☐ Reinstate Coverage
- ☒ Adjustment Indicated Below

Attachments:

- ☐ Copy of Payroll/Direct Payment Report
- ☐ Copy of Adjustment Report
- ☐ All Necessary Membership Documentation
- ☐ Other Documentation

Discrepancy:

☒ Payroll indicates member is over/underpaid (-/+):
☐ Health $ _____ ☐ Dental $ _____ ☒ Life $ _____ ☐ FSA $ _____

☐ Adjustment report indicates member is over/underpaid (-/+):
☐ Health $ _____ ☐ Dental $ _____ ☐ Life $ _____ ☐ FSA $ _____

☐ Untimely Filing refund to purge:
☐ Health $ _____ ☐ Dental $ _____ ☐ Life $ _____ ☐ FSA $ _____

☐ Overpayment Over 6 months no longer eligible for refund:
☐ Health $ _____ ☐ Dental $ _____ ☐ Life $ _____ ☐ FSA $ _____

Additional Comments: