Special Enrollment Form – Health Plan Changes ONLY

Member Name: _____ **SSN:** _____-____-_____

You must complete, sign and return this form to your agency Group Insurance Representative (GIR) or agency Benefits Office no later than October 28, 2011. This new election will be effective December 1, 2011. **Please note, you may only change your health carrier during this Special Enrollment Period; you cannot add or drop dependents, or enroll in MCAP or change your MCAP election.**

If you are electing an HMO plan, you must complete the **Primary Care Physician (PCP) Election** section below indicating a Primary Care Physician (PCP) for you and each of your dependents. If you elect the Quality Care Health Plan (QCHP) or one of the Open Access Plans, you need only indicate the health plan, making sure to sign and date the form.

Health Carrier Election (select one – if electing a managed care plan, please ensure the option you elect is available in your area. A map indicating the carriers by county is available in the Benefit Choice book at www.benefitschoice.il.gov).

_____	**HMO Illinois (BY)**	**800/868-9520**	**800/888-7114 (TDD/TTY)**
_____	**BCBS BlueAdvantage HMO (CI)**	**800/868-9520**	**800/888-7114 (TDD/TTY)**
_____	**HealthLink Open Access Plan (CF)**	**800/624-2356**	**800/624-2356, ext. 6280 (TDD/TTY)**
_____	**PersonalCare HMO (AS)**	**800/431-1211**	**217/366-5551 (TDD/TTY)**
_____	**PersonalCare Open Access Plan (CH)**	**800/431-1211**	**217/366-5551 (TDD/TTY)**
_____	**Health Alliance HMO (AH)**	**800/851-3379**	**217/337-8137 (TDD/TTY)**
_____	**Health Alliance Illinois (BS)**	**800/851-3379**	**217/337-8137 (TDD/TTY)**
_____	**Quality Care Health Plan (QCHP)**	**800/962-0051**	**800/526-0844 (TDD/TTY)**

Primary Care Physician Election (only complete if you elected an HMO plan)

Member Name	**Primary Care Physician Name**	**Provider Identifier #**
_____	_____	_____
Dependent(s) Name	**Primary Care Physician Name**	**Provider Identifier #**
_____	_____	_____
_____	_____	_____
_____	_____	_____

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. The information contained in this form is complete and true. 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. I understand 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. Additionally, the Department of Central Management Services (CMS) may impose a financial penalty, including, but not limited to, repayment of all premiums the Program made on behalf of the enrolled individual, as well as expenses incurred by the Program.

Member Signature _____ Date _____

GIR Signature _____ Date _____

Please return this form to your GIR or Benefits Office