State Employees' Group Insurance Program

SURS Group Insurance Enrollment/Change Form

(Annuitants and Survivors should use this form for enrollment/changes.)

New and existing retirees and survivors should use this form to elect coverage for the first time or change coverage elections during the plan year.

Complete this enrollment form and return it to SURS within 60 days of experiencing a qualifying event. Changes will be effective the later of: the date of the event, or the date received in SURS office. In some instances when adding a dependent, the effective date will be the first of the month following the request. If you elect dependent health coverage, your dependent will be enrolled in the same plan as you.

Change Current Election and/or Add Dependent(s): If you wish to change any of your current elections, **only complete the Member Information section and the information you wish to change**. If you are enrolling dependent(s) during the plan year, also complete the Dependent Information section on page 2. If you are adding/changing more than four dependents, please use additional copies of page 2. Please mail or fax the first two pages **with your signature on page 2.**

Member Information

☐ **Change Election – Reason Code ___** **(see page 3 for reason codes)**

☐ **Initial Enrollment** ________________

Date of Qualifying Event ______________

Effective Date ________________

Last Name	First Name (legal)	Middle Name	Social Security Number (required)	Residential County

Residential Street Address	City	State	Zip	Email address

Primary Phone Number	Alternate Phone Number	Is your Spouse a State Employee or Annuitant?	Gender	Are you Disabled?
		☐ No ☐ Yes, agency ______________________	☐ Male ☐ Female	☐ Yes ☐ No

Date of Birth	Marital Status	Medicare Status (If you have Medicare, you must provide a copy of the Medicare card)
	☐ Single ☐ Married	☐ Non-Medicare ☐ Ineligible Age 65+ ☐ Age 65+ ☐ Disability ☐ End Stage Renal Disease

Health Insurance Coverage Election (includes vision)

☐ **Please (1) enroll me in health coverage or (2) change my health plan election.** Members must choose their health plan election below. If enrolling after experiencing a break in coverage, employees must submit a Certificate of Creditable Coverage to SURS. Members who have less than 20 years of service will be required to share in the cost of insurance benefits as well as dependent benefits.

HMO's - must include the 10-digit National Provider Identifier (NPI) which can be found on the provider's website.

Health Plan Name	National Provider Identifier #	Health Plan Name	National Provider Indentifier #
☐ Quality Care Health Care Plan (D3)		☐ HMO Illinois (BY) *	#________________
☐ HealthLink OAP (CF)		☐ Blue Advantage HMO (CI) *	#________________
☐ Coventry OAP (CH)			
☐ Coventry HMO (AS)	#________________		
☐ Health Alliance HMO (AH)	#________________		

*** For plans CI or BY, also enter 3-digit Medical Group ________**

Coordination of Benefits

☐ Yes, either I or my covered dependents have other group health coverage.

If 'Yes,' you must provide a copy of the other group health ID card.

☐ No, I do not have other group health coverage.

☐ **I do not want health, prescription, dental and vision coverage.** Annuitants with premium-free health insurance must provide proof of other group health coverage provided by an entity other than CMS in order to OPT OUT of the coverage. Member must complete an Opt Out form.

Dental Insurance Coverage Election

(If you have another group dental plan you must provide a copy of the front and back of the dental ID card to SURS for coordination of dental benefits.)

New Annuitants or Survivors or Those Opting Back Into Group Insurance	☐ Yes, I want the dental coverage	☐ No, I do not want the dental coverage. I understand if I choose not to enroll in dental, I cannot enroll until the next annual Benefit Choice Period.

Member's signature is required on page 2 to process any insurance changes

ONLY COMPLETE THE SECTIONS YOU WISH TO ADD OR CHANGE

Life Insurance Coverage Election (Deferred annuitants are eligible for basic life only.) ☐ Add ☐ Drop

BASIC and OPTIONAL LIFE †				AD&D (Accidental Death & Dismemberment)	Dependent Life Coverage ($10,000 each) †
☐ Basic Life Only - equal to your annual salary (Free) Annuitants age 60 and over, basic life insurance drops to $5,000. ☐ Basic and Optional Life (select optional coverage increment below) Annuitants age 60 and over are not eligible for 5-8x salary. ☐ Survivor $5,000 optional life - (Monthly premium based on age) Only Survivors of Immediate Annuitants are eligible.				☐ NO AD&D ☐ BASIC only (Equal to Salary) ☐ COMBINED (Equal to Basic Life + Optional Life*) * AD&D Combined will not exceed 4 times optional	☐ NONE ☐ CHILD* ☐ SPOUSE OR CIVIL UNION PARTNER** * All dependent children age 25 and under are eligible for life coverage, except for those enrolled in the "other" category **Spouse life reduces to $5,000 when annuitant attains age 60. Note: If electing Child or Spouse Life you must complete the 'Dependent Information' section below.
☐ 1 x Salary	☐ 3 x Salary	☐ 5 x Salary	☐ 7 x Salary		
☐ 2 x Salary	☐ 4 x Salary	☐ 6 x Salary	☐ 8 x Salary		

† After Initial Enrollment: Optional Life requests in any increment (1 – 8 times) and Survivor Optional Life require completion of a Statement of Health application.
After Initial Enrollment: Spouse and Child Life requests for dependents that are not newly added due to marriage or birth require completion of a Statement of Health application.

Dependent Information – All dependent enrollments require additional documentation to be submitted verifying eligibility (see page 3 for documentation requirements).

Add (A); Drop (D) or Change (C)		Name (legal) (First Middle Last)	SSN (Required)	Date of Birth [1]	Relationship Type (see list below)	Primary Physician (only for managed care)	Sex (M/F)	Other Coverage[2] (Y/N)
HEALTH	LIFE							

[1] If you have dependents with the same birth date including year (e.g. twins), in addition to the birth date you must put a #1 in the **Date of Birth (DOB) field** on the line of the child who was born first; put a #2 in the DOB field for the child who was born second, etc.

[2] If your dependent has other group health or dental coverage, including Medicare, you must provide a copy of the front and back of the card to SURS.

Relationship Types are:

• Spouse (01) • Civil Union Partner (Non-IRS – 1C; IRS – 1D) • Natural Child (02) • Adopted Child (03) • Stepchild (04) • Civil Union Child (Non-IRS – 4A; IRS – 4B)
• Legal Guardianship (06) • Adjudicated Child (07)

Relationship Types for all other children (age 19 or older). A CMS-138 form-CMS Dependent Certification Form **must accompany enrollment requests for these dependents (available at www. benefitschoice.il.gov or SURS website).**

• Disabled Dependent (09) • Other (transplant recipient – 10) • Veteran Adult Child (Non-IRS – 13; IRS - 14/15)

I authorize premiums as established annually to be deducted from my benefit for those plans I have selected. I understand that if my benefit check is insufficient, 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 benefit check and verify the amounts of the insurance deductions are accurate. I understand that if my deductions are not correct, I must immediately contact SURS. The Department of Central Management Services (CMS) may also 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 due to falsification of the information contained on this form.

Annuitant/Survivor Signature: ____________________________________ Date: ____________________

GIR/P USE ONLY: Effective Date: ____________

Org Proc Code: ________________

GIR/GIP SIGNATURE: ____________________________________ DATE: ____________________

Reason Code	Reason and Required documentation
01	Divorce/Legal Separation/Annulment of a member (copy of divorce decree or other legal document)
02	Death of spouse/civil union partner or dependent (copy of death certificate)
03	Change in member or spouse's employment status (part-time to full-time status or vice versa, letter from employer on employer letterhead)
04	Spouse's employer makes significant changes in premium costs (30% or greater in change) or coverage (letter from spouse's insurance carrier on their letterhead)
05	Spouse is provided group insurance through employer for the first time (letter from spouse's insurance carrier on their letterhead)
06	Member retiring with SURS
07	Dependent becomes eligible for other coverage (documentation supporting eligibility that indicates the date the dependent met the eligibility criteria)
08	Court order results in the member gaining or losing custody of a dependent (copy of court order)
09	Court decree establishes a member's financial responsibility for a child's medical, dental, or other health care – Adjudicated child (copy of court order)
10	Change in Medicaid or Medicare status (copy of letter from Medicaid or Medicare)(Medicare status – can only enroll if losing, not gaining Medicare)
11	Coordination of spouse's annual election period. Member's request to change coverage must be consistent with and on account of the spouse election (written statement from spouse's plan indicating this is the only time dependent coverage can be changed)
12	Marriage (copy of marriage certificate)
13	Birth (copy of birth certificate)
14	Adoption or placement for adoption (copy of adoption papers)
15	Spouse loses employment (letter from previous employer on their letterhead)
16	Spouse's employer discontinues ALL coverage (letter from employer on their letterhead)
17	Dependent becomes ineligible for other coverage (letter from previous insurance company on their letterhead or Certificate of Creditable Coverage)
18	Member loses other coverage (reason other than non-payment of premium)(letter from employer or insurance carrier)
19	Spouse ineligible for other coverage/loses other coverage (Certificate of Creditable Coverage or letter from employer or insurance carrier)
20	Change in member's county of residence

Special Circumstances- The following plan changes may be made at any time during the plan year. Changes are restricted to the plan affected by the circumstance.

21	Change in spouse or child life, and/or AD&D coverage
22	Add or drop in dependent health coverage in the 2+ premium group (minimum of two remaining dependents required)
23	Changes in life insurance where premiums are paid by annuitants or survivors

Refer to Qualify Change in Status charts in State of Illinois Benefits Handbook pages 13 - 16

Benefits Website: www.surs.org

SURS Fax: 217-378-9800