

State Employees' Group Insurance Program Employee Group Insurance Enrollment/Change Form

(Annuitants and Survivors should contact their retirement system for the appropriate enrollment/change forms)

New and existing employees should use this form to elect coverage for the first time or change coverage elections during the plan year. Existing employees wishing to make a change should contact their [Group Insurance Representative \(GIR\)](#) to determine if they have a qualifying event and if so, the date the change would be effective and any documentation requirements. All employees should periodically update their [Beneficiary Forms](#). All part-time employees must also complete the [Part-time Election form](#).

New Hire: Complete this enrollment form and return it to your GIR within 10 days of your hire date. Coverage will be effective retroactive to your hire date. If you elect dependent health coverage, they will be enrolled in the same plan as you. **FAILURE TO RETURN THIS FORM** to your Benefits Office within 10 days of your hire date will result in automatic enrollment in the Quality Care Health Plan and Quality Care Dental Plan with no dependent coverage and Basic Life coverage only.

Change Current Election and/or Add Dependent(s): If you wish to change any of your current elections, **only complete the Employee 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 your dependent resides at a different address than you, complete the [Address Change](#) form. If you are adding/changing more than four dependents, please use additional copies of page 2.

Employee Information		<input type="checkbox"/> Initial Enrollment	Date of Hire _____	
		<input type="checkbox"/> Change Election - Reason	Date of Event _____	
Last Name		First Name (legal)		Middle Name
				Social Security Number (required)
Residential Street Address		City		State
				Zip
				Employment Status
				<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time (must complete Part-time Election form)
Home Phone Number		Work Phone Number		Is your Spouse a State Employee/Annuitant?
				<input type="checkbox"/> No <input type="checkbox"/> Yes, agency _____
				Gender
				<input type="checkbox"/> Male <input type="checkbox"/> Female
				Are you Disabled?
				<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of Birth	Marital Status		Medicare Status (If you have Medicare, you must provide a copy of the Medicare card)	
	<input type="checkbox"/> Single <input type="checkbox"/> Married		<input type="checkbox"/> Non-Medicare <input type="checkbox"/> Ineligible Age 65+ <input type="checkbox"/> Age 65+ <input type="checkbox"/> Disability <input type="checkbox"/> End Stage Renal Disease	

[Health Insurance Coverage Election \(includes vision\)](#)

<input type="checkbox"/> Please (1) enroll me in the health coverage or (2) change my health plan election. Employees must choose their health plan election below. If enrolling after experiencing a break in coverage, employees must submit a Certificate of Creditable Coverage to their GIR.					
<input type="checkbox"/> Quality Care Health Plan (D3)			Coordination of Benefits		
<input type="checkbox"/> Managed Care Plans - You must complete the information below, including the 6 or 10 character Provider Identifier #. The Provider Identifier # can be found by contacting the managed care plan directly via their website or by phone.			<input type="checkbox"/> 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. <input type="checkbox"/> No, I do not have other group health coverage.		
<u>Health Plan Name</u>		<u>Provider Identifier #</u>			
<input type="checkbox"/> Health Alliance HMO (AH) _____		<input type="checkbox"/> Humana Benefit Plan of Illinois (CA) _____			
<input type="checkbox"/> Health Alliance Illinois (BS) _____		<input type="checkbox"/> Humana Benefit Plan of Winnebago (CE) _____			
<input type="checkbox"/> HealthLink Open Access (CF) _____		<input type="checkbox"/> PersonalCare (AS) _____			
<input type="checkbox"/> HMO Illinois (BY) _____					
<input type="checkbox"/> I do not want health, prescription, dental and vision coverage. Full-time employees must provide proof of other group health coverage provided by an entity other than CMS in order to OPT OUT of the coverage (employees must complete an Opt Out form). Part-time employees do not need to have other coverage in order to waive.					

[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 your GIR for coordination of dental benefits)

New Employees or Full-time Employees Opting Back Into Group Insurance	<input type="checkbox"/> Yes, I want the dental coverage	<input type="checkbox"/> 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.
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Complete page 2 of this form to add or change life and/or dependent coverage

ONLY COMPLETE THE SECTIONS YOU WISH TO ADD OR CHANGE

Employee Name: _____
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[Life Insurance Coverage Election](#)

BASIC and OPTIONAL LIFE †				AD&D (Accidental Death & Dismemberment)	Dependent Life Coverage (\$10,000 each) †
<input type="checkbox"/> Basic Life Only - equal to your annual salary (Free) <input type="checkbox"/> Waive Basic and Optional Life (only available to employees on certain LOAs) <input type="checkbox"/> Basic and Optional Life (select optional coverage increment below)				<input type="checkbox"/> NO AD&D <input type="checkbox"/> BASIC only (Equal to Salary) <input type="checkbox"/> COMBINED (Equal to Basic Life + Optional Life*) * AD&D Combined will not exceed 4 times optional	<input type="checkbox"/> NONE <input type="checkbox"/> CHILD * <input type="checkbox"/> SPOUSE *Only children under age 19, Students (age 19 - 24) and Handicapped dependents are eligible for life coverage Note: If electing Child or Spouse Life you must complete the 'Dependent Information' section below.
<input type="checkbox"/> 1 x Salary	<input type="checkbox"/> 3 x Salary	<input type="checkbox"/> 5 x Salary	<input type="checkbox"/> 7 x Salary		
<input type="checkbox"/> 2 x Salary	<input type="checkbox"/> 4 x Salary	<input type="checkbox"/> 6 x Salary	<input type="checkbox"/> 8 x Salary		

† New Hires: Only Optional Life requests in amounts of 5 – 8 times require completion of a [Statement of Health application](#).
 After Initial Enrollment: Optional Life requests in any increment (1 – 8 times) 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 your GIR 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)	Provider Identifier # (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 your GIR.

Relationship Types are:

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

The following Relationship Types apply to children age 19 or older and require completion of a [CMS-138 form](#) available on the Benefits website.

- Student (08) • Handicapped Dependent (09) • Sponsored Adult Child (Non-IRS – 11; IRS - 12) • Veteran Adult Child (Non-IRS – 13; IRS - 14)
- Student Military Extension (8B) • Other (transplant recipient – 10)

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.

Employee Signature: _____

Date: _____

[Who is my GIR?](#) Go to 'Contact Information' on the Benefits Website.

GIR/P USE ONLY: Payroll Deduct Codes: Health: _____ Dental: _____ Life: _____ Non-IRS Dep: Health: _____ Dental: _____
 Effective Date: _____ Type/Subtype: _____ PT%: _____ Salary: _____ Deduct Frequency (M/S): _____
 Distribution Code: _____ Payroll Agency: _____ Work County Code: _____ Org Proc Code: _____
 Change in Status Reason Code: _____ Dependent Term Code: _____ Pre-Existing Months _____
 GIR/GIP SIGNATURE: _____ DATE: _____