STATE RETIREMENT SYSTEMS

- State Employees' Retirement System of Illinois
- General Assembly Retirement System
- Judges' Retirement System of Illinois

Internet: http://www.srs.illinois.gov Email: sers@srs.illinois.gov

2101 South Veterans Parkway, P. O. Box 19255, Springfield, IL 62794-9255

Office Use Only:

BH: _____

Online:_____

Member Group Insurance Change Form

(This form is a required document and must be completed)

Change/Terminate Current Election(s) and/or Add/Terminate Dependent(s): If you wish to change any of your current elections due to a Qualifying Event, **only complete the Member Information section and the information you wish to change.** If you are enrolling dependent(s) during the plan year due to a Qualifying Event, also complete the Dependent Information section on the back of this form. There is a 60 day window from the date of the qualifying event to submit this document and the required documents. The effective date will be the date all documents are received in our office. If received past the 60 day window, we will be unable to process your request. The next available window to make a change will be during the annual Benefit Choice Period held each May with change requests effective July 1st of that year. Reductions to life insurance can be made anytime during the year and documentation is not required when reducing optional life insurance.

SECTION A: Member Information (completion required)

☐ **Change Election - Qualifying Reason** _____

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

Residential Street Address	City	State	Zip	EMAIL ADDRESS (optional)

Home Telephone Number	Alternate Telephone Number	Is your Spouse or Civil Union Partner 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+ ☐ Eligible Age 65+ ☐ Disability ☐ End-Stage Renal Disease

ONLY COMPLETE THE SECTIONS YOU WISH TO CHANGE

SECTION B: Coverage Election (check one box only - Annuitants must provide proof of other group health coverage (gained within the past 60 days) provided by an entity other than CMS in order to drop the coverage.

☐ **I elect to terminate health,prescription,dental and vision**

☐ **I elect dental only and wish to terminate health,prescription and vision coverage**

☐ **I am non Medicare and elect to terminate health,prescription,dental and vision coverage and enroll in the Financial Incentive Program (for retirees only). A packet will be sent to you. Incentive amounts are $150 per month (if you have less than 20 years of service) or $500 per month (if you have 20 or more years of service).**

SECTION C: Health Insurance Election "CHANGING PLANS DUE TO A QUALIFYING EVENT"

Check the appropriate box below for your health plan election. Members choosing an HMO must complete the 10 digit Provider Identifier #. The Provider Identifier # can be found by contacting the HMO plan administrator by phone or the plan's website.

Health Plan Name	HMO Health Plan Name	10 digit Provider Identifier #	HMO Health Plan Name	10 digit Provider Identifier #
☐ Quality Care Health Plan (Cigna)			☐ HMO Illinois (BY)	_____
☐ Coventry OAP (CH)	☐ Coventry HMO (AS)	_____	3 digit Medical Group #	_____
☐ HealthLink OAP (CF)	☐ Health Alliance HMO (AH)	_____	☐ BlueAdvantage HMO (CI)	_____
			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, Including Medicare.**

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

Complete page 2 of this form to add or change life and/or dependent coverage

SECTION D: Life Insurance Coverage Election

BASIC and MEMBER OPTIONAL LIFE'				AD&D (Accidental Death & Dismemberment)	Dependent Life Coverage
☐ Basic Life Only (equal to annual salary) — Basic Life is free and automatic for all members ☐ Basic and Member Optional Life (select optional coverage increment below)				☐ NO AD&D ☐ BASIC only (Equal to Salary) ☐ COMBINED (Equal to Basic Life + Optional Life*) * AD&D Combined will not exceed 4 times optional	☐ ADD CHILD LIFE * **$10,000** ☐ TERMINATE CHILD LIFE ☐ ADD SPOUSE or CIVIL UNION PARTNER LIFE **($10,000 if member is below age 60. $5,000 if member is age 60 or above.)** ☐ TERMINATE SPOUSE or CIVIL UNION PARTNER LIFE • All dependent children age 25 and under are eligible for life coverage, except individuals enrolled in the 'Other" category.
☐ 1 x Salary	☐ 3 x Salary	☐ **5 x Salary**	☐ **7 x Salary**		
☐ 2 x Salary	☐ 4 x Salary	☐ **6 x Salary**	☐ **8 x Salary**		

**** Only Retirees under age 60 can elect Optional Life requests in amounts of 5 — 8 times. Requires completion of a Statement of Health application for approval.**
Retirees age 60 and above can elect up to 4X the basic $5,000. Requires completion of a Statement of Health application for approval.
After Initial Enrollment: Spouse or Civil Union Partner and Child Life requests for dependents that are not newly added due to marriage, civil union or birth require completion of a Statement of Health.

SECTION E: Dependent Information - All dependent enrollments require additional documentation to be submitted verifying eligibility (see your requirements below).

Add (A); Drop (D) or Change (C)		Name (legal)	SSN (Required)	Date of Birth [1]	Relationship Type (see list below) CODE # IS REQUIRED	10 Digit Provider Identifier # (only required for HMO plan coverage)	Sex (MF)	Other Coverage [2] (Y/N) Including Medicare If Yes, attach copy
HEALTH	LIFE	(First Middle Last)						

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 attach a copy of the front and back of the card to this form.**

Relationship Types for Spouse/Civil Union Partner and children age 25 and under:

- Spouse (Code # 01) Same Sex Spouse (Code 1F) **Requires a copy of the marriage certificate**
- Civil Union Partner (Non-IRS - Code # 1 C; IRS - Code # 1 D) - **Requires a copy of the civil union certificate**
- Natural Child (Code # 02) **Requires a copy of the child's birth certificate**
- Adopted Child (Code # **03)Requires a copy of the adoption papers, (birth certificate is also needed to verify birthdate)**
- Stepchild (Code # 04) **Requires copies of the marriage and birth certificates**
- Civil Union Child (Non-IRS - Code # 4A; IRS - Code # 4B) **Requires copies of the civil union certificate and child's birth certificate**
- Legal Guardianship (Code # 06) **Requires a copy of the guardianship document, (birth certificate is also needed to verify birthdate)**
- Adjudicated Child (Code # 07) **Requires a copy of the legal court document**

REQUIRED DOCUMENTS:
When adding a dependent(s) due to a loss of medical coverage, you must provide proof of the date of loss of the coverage (certificate of coverage or letter from the Company). When terminating a dependent(s) due to the gain of other medical coverage, you must provide proof of the date of gain (certificate of coverage or letter from the Company).

Relationship Types for all other children (age 19 or older). A CMS-138 form must accompany enrollment requests for these dependents (available on SERS Insurance website). Other backup documentation will be required. Please consult with your SERS Group Insurance Representative.
• Disabled (Code # 09) • Other (transplant recipient - Code # 10) • Adult Veteran Child (Non-IRS - Code # 13) • Adult Veteran Child (IRS - Code #14/15)

I authorize premiums as established annually to be deducted from my check for those plans I have selected. I understand that if my 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 check and verify the amounts of the insurance deductions are accurate. I understand that if my deductions are not correct I must immediately contact my SERS Group Insurance Representative. Falsification of the information contained on this form may result in the Department of Central Management Services (CMS) imposing 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:** _____

SERS Group Insurance Representative Signature: _____ **Date:** _____