JRS Judges' Retirement System
srs.illinois.gov

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# Retiree & Survivor Insurance Form

**Please note that this is a required form.** If you fail to submit this form before your retirement/survivor annuity date, your coverage will be terminated. If you submit the form after the retirement/survivor annuity date but within 60 days of your payable benefit date, you may still elect coverage with an effective date of the first day of the month in which we receive the form. If you fail to return the form or elect not to participate in health/dental coverage, you are eligible to participate at a later date by enrolling during the annual Benefit Choice Period or within 60 days of experiencing a qualifying change in status.

*A survivor who was not a covered dependent at the time of the member's death will be effective the first day of the month following the member's death.*

## Member/payee information

**Name** *(Last, first, middle)*

**Effective date of your benefit** *(MM/DD/YY)*

**Residential address** *(Street, City, State, Zip) (No P.O. Box)*

**SSN (last 4) or Member ID**

**Mailing address** *(if different than street address) (Street, City, State, Zip)*

**Date of birth**

**Email address**

**Phone number(s)**
(H)
(C)

## Health election

- ☐ I elect to keep my current state insurance coverage the same as what I currently have.
- ☐ I wish to keep my state insurance, but request to make changes.*
- ☐ I am not currently enrolled in the state insurance program, but wish to enroll. *(You must indicate which plan you wish to be covered under.)**

**Plan name:** _____

## Dental election

- ☐ I elect to be enrolled with dental coverage and understand that premiums apply.
- ☐ I do not wish to have dental coverage at this time. I understand that if I would like dental coverage in the future, I may only elect it during the annual Benefit Choice Period.

## Life insurance election

- ☐ I elect to keep my current optional life insurance coverage, and understand that premiums apply.
- ☐ I do not wish to keep my optional life insurance and/or spouse/child optional life insurance, and I understand coverage terminates on my retirement date.

## Opt-out election

- ☐ I elect to opt out of the health insurance program and I will be enrolled with basic life insurance coverage only.*

## Members currently enrolled as a dependent

- ☐ I am currently enrolled as a dependent on my state-covered spouse's health, dental and vision coverage for at least one year; therefore, I qualify to remain as a dependent on that policy. I understand that by waiving my coverage as a retiree to remain a dependent on my spouse's policy, the only coverage I qualify for as a retiree (member) is basic life insurance coverage.

**Please visit **MyBenefits.Illinois.gov** or contact them at 844-251-1777 to get the appropriate forms and information.*

## Medicare status

If the Social Security Administration determines you and/or your dependent(s) are Medicare eligible (age 65 and older or under age 65 due to disability) and you and/or your dependents have not enrolled in Medicare Parts A and B, **you are required to enroll prior to the effective date of your retirement**.

## Check one of the following:

☐ Not enrolled: I am not Medicare eligible.

☐ Enrolled: Part A Hospital/Part B Medical: I will provide JRS with a copy of my Medicare card.

☐ Enrolled: Part A - Hospital only: I will enroll in Part B and provide JRS with a copy of my Medicare card.

☐ Enrolled: Part B - Medical only: If SSA determines I am eligible, I will enroll in Part A and provide JRS with a copy of my Medicare card.

***Note: Failure to enroll and maintain enrollment in Parts A and B (when Medicare is the primary insurance payer) results in a reduction of benefits and additional out-of-pocket expenses for medical services.***

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## Are you electing coverage for eligible dependents?

*(See pages 8-9 of the State Retiree, Annuitant and Survivor Benefits Handbook; go to **srs.illinois.gov/JRS/Member/Retiree/Survivor Information** and click on the "Insurance" link for eligibility requirements.)*

☐ Yes ☐ No

If yes, complete the dependent(s) information below. Please include a copy of your marriage certificate (if adding a spouse) and a copy of the birth certificate for each dependent you want to enroll.

| Dependent name | Social Security number | Date of birth |
|---|---|---|
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**If you and/or your dependents are enrolled in any other group insurance program other than Medicare, please contact your insurance carrier with the information.**

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*By signing below I certify this information is correct and that I am aware that knowingly making a false statement or falsifying a record in an attempt to defraud JRS is a class 3 felony. I understand that if the JRS Board of Trustees has a reasonable suspicion that an attempt has been made to defraud JRS, it is required to report the matter to the appropriate State's Attorney for investigation.*

**Member signature** _____ **Date** _____