State of Illinois
Department of Central Management Services

STATE EMPLOYEES' MCAP ENROLLMENT FORM

MEDICAL CARE ASSISTANCE PLAN
for the FY2017 Plan Year (July 1, 2016 - June 30, 2017)

The MCAP program is for reimbursement of eligible medical expenses, such as copayments, deductibles, eligible over-the-counter items, etc., for the member and any eligible dependents. All medical care expenses and services must be rendered by June 30, 2017, in order to be eligible for reimbursement.

Last Name _____ First Name _____ MI ____ SSN _____

Street _____ City _____ State ____ ZIP Code _____

Primary Phone _____ Secondary Phone _____ Agency _____

☐ Benefit Choice ☐ Initial Enrollment (due to beginning employment) - New Hire Date: _____

☐ Mid-Year Enrollment - Change in Status Code required (see chart below): _____

I certify that the above eligible change in status event occurred on _____ *and that the change is* ***on account of and consistent with*** *the nature of the qualifying event.*

_____ ÷ _____ = _____

Total Annual MCAP Amount (Annual Minimum = $240) (Annual Maximum = $2,550) | # of Deductions | Amount Per Pay Period

*Benefit Choice enrollment - enter either 12 or 24 (may be less for a university employee);
Midyear enrollment - enter the number of deductions remaining in the plan year.

Change in Status Code Chart

01 Adoption of dependent *
02 Marriage
03 Divorce, legal separation or annulment *
07 Change of county of residence/work site for employee or spouse *
08 Judgment, decree or court order *
10 Employee commences employment
11 Employee returns to payroll (from being on a leave of absence)
13 Employee changes employment status from Part-time less than 50% to greater than 50%
15 Spouse or dependent terminates employment
17 Spouse or dependent changes employment status from Full-time to Part-time
20 Spouse enters leave of absence and loses FSA enrollment
24 Coordination of spouse's annual benefit election period *

* Change in status codes indicated with this symbol must include a written statement explaining how the requesting change is on account of, and consistent with, the qualifying event. Changes in status will be reviewed and approved by the FSA Unit on a case-by-case basis and additional documentation may be required. You may contact the FSA Unit at 1-800-442-1300 with any questions.

I understand and certify that:

- I may not change or stop my account deposits during the plan year unless I experience a qualifying change in status.
- I must submit reimbursement claims for medical expenses that were incurred on or prior to June 30th by the last day of the run-out period which is 90 days after the last day of the plan year (i.e., September 30th).
- I must re-enroll in MCAP for the new plan year in order to qualify for the rollover benefit of up to $500. If I do not re-enroll, I will forfeit any unclaimed amount remaining in my account at the end of the run-out period which is September 30th.
- Deductions must continue during any paid leave of absence.
- I intend to participate in MCAP for the entire plan year. I do not anticipate terminating state service, retiring or going on an unpaid leave of absence.
- I will refund to CMS any incorrect reimbursements or ineligible payments. If I do not repay the debt, the State may take whatever steps necessary to collect the amount owed.
- The IRS Grace Period that applied to previous plan years will no longer apply to this plan year or future plan years.
- If my payroll deductions cease for any reason, I understand my participation in the program will terminate on the last day of the pay period in which a check was issued, unless I elect to continue my participation through direct payments to the FSA Unit for the remainder of the plan year.
- To the best of my knowledge, the information on this form is accurate. I am responsible for any discrepancies that may affect my status with the IRS.

By signing this form, I authorize the State of Illinois to deduct the amount indicated from each paycheck for my MCAP account.

Employee Signature: _____ Date _____

GIR Use Only

Org Proc Code: _____ Pay Code: _____ Telephone: _____

Effective Date: _____ Deduction Start Date: _____

Enter a Deduction End Date if enrollment is for a university employee paid over 9 months: _____

GIR Signature: _____ Date: _____

GIR Instructions: ***Use the "DEDUCTION WHAT IF SCREEN" (option #1 or #2) to ensure member's enrollment information is accurate.***
Forward a copy to the FSA Unit at CMS, a copy to payroll and retain a copy in the member's file.

Central Management Services requests disclosure of information that is necessary to establish its obligations, primarily the statutory purposes under the Department of Central Management Services Law (20 ILCS 405). Disclosure of the information requested on this form is mandatory, and failure to provide requested information may result in rejection of this form or delay in making a determination of eligibility. Social Security numbers are used in the enrollment process to properly identify members. Confidentiality of Social Security numbers obtained through this change of address process will be preserved as prescribed by 5 ILCS 179 et seq.