

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 must 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		Email Address: _____	
		<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 also complete Part-time Election form)
Primary Phone Number	Alternate Phone Number		Is your Spouse/Civil Union Partner a State Employee/Annuitant?		Gender
			<input type="checkbox"/> No <input type="checkbox"/> Yes, agency _____		<input type="checkbox"/> Male <input type="checkbox"/> Female
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	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	

[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.	Coordination of Benefits																				
<p>Check the appropriate box below for your health plan election. Members choosing an HMO must complete the 10-digit National Provider Identifier (NPI) number. The NPI # can be found by contacting the HMO plan administrator by phone or the plan's website. Members choosing BlueAdvantage HMO or HMO Illinois must also complete the 3-digit medical group field.</p> <table><tr><td>Health Plan Name</td><td>HMO Health Plan Name</td><td>Provider Identifier #</td><td>HMO Health Plan Name</td><td>Provider Identifier</td></tr><tr><td><input type="checkbox"/> Quality Care Health Plan</td><td><input type="checkbox"/> Health Alliance HMO (AH)</td><td>_____</td><td><input type="checkbox"/> BlueAdvantage HMO (CI)</td><td>_____</td></tr><tr><td><input type="checkbox"/> HealthLink OAP (CF)</td><td><input type="checkbox"/> Coventry HMO (AS)</td><td>_____</td><td><input type="checkbox"/> HMO Illinois (BY)</td><td>_____</td></tr><tr><td><input type="checkbox"/> Coventry OAP (CH)</td><td></td><td></td><td colspan="2">For plans CI or BY, enter 3-digit Medical Group below: _____</td></tr></table>	Health Plan Name	HMO Health Plan Name	Provider Identifier #	HMO Health Plan Name	Provider Identifier	<input type="checkbox"/> Quality Care Health Plan	<input type="checkbox"/> Health Alliance HMO (AH)	_____	<input type="checkbox"/> BlueAdvantage HMO (CI)	_____	<input type="checkbox"/> HealthLink OAP (CF)	<input type="checkbox"/> Coventry HMO (AS)	_____	<input type="checkbox"/> HMO Illinois (BY)	_____	<input type="checkbox"/> Coventry OAP (CH)			For plans CI or BY, enter 3-digit Medical Group below: _____		<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.
Health Plan Name	HMO Health Plan Name	Provider Identifier #	HMO Health Plan Name	Provider Identifier																	
<input type="checkbox"/> Quality Care Health Plan	<input type="checkbox"/> Health Alliance HMO (AH)	_____	<input type="checkbox"/> BlueAdvantage HMO (CI)	_____																	
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<input type="checkbox"/> Coventry OAP (CH)			For plans CI or BY, enter 3-digit Medical Group below: _____																		
<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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ONLY COMPLETE THE SECTIONS YOU WISH TO ADD OR CHANGE

Employee Name: _____
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Life Insurance Coverage Election

BASIC and MEMBER OPTIONAL LIFE [†]				AD&D (Accidental Death & Dismemberment)	Dependent Life Coverage (\$10,000 each) [†]
<input type="checkbox"/> Basic Life (equal to annual salary) – Basic Life is free and automatic for all employees except those on certain LOA's, in which case the employee must elect the coverage and pay 100% of cost <input type="checkbox"/> Waive Basic and Member Optional Life (only applies to employees on certain LOAs) <input type="checkbox"/> Basic and Member Optional Life (select optional coverage increment below)				<input type="checkbox"/> NO AD&D <input type="checkbox"/> BASIC AD&D (Equal to one times salary) <input type="checkbox"/> COMBINED AD&D (Equal to one times salary + Optional Life amount *) * AD&D Combined has a maximum of 4 times the Optional Life amount	<input type="checkbox"/> NONE <input type="checkbox"/> CHILD * <input type="checkbox"/> SPOUSE or CIVIL UNION PARTNER * All dependent children age 25 and under are eligible for life coverage, except individuals enrolled in the 'Other' category. Note: If electing Child or Spouse/Civil Union Partner Life you must complete the 'Dependent Information' section.
<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 Member Optional Life requests in amounts of 5 – 8 times require completion of a [Statement of Health application](#).
 After Initial Enrollment: Member Optional Life requests in any increment (1 – 8 times) require completion of a [Statement of Health application](#).
 After Initial Enrollment: Spouse/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](#).

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)	Sex (M/F)	Other Coverage ² (Y/N)	NPI # (only required for HMO plan coverage)	Medical Group (3 digits)
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 for Spouse/Civil Union Partner and children age 25 and under:

- 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](#) must accompany enrollment requests for these dependents (available on the Benefits website).

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

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 Dependent: 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: _____ Date of Hire: _____ (initial enrollments only)

GIR/GIP SIGNATURE: _____ DATE: _____



Beneficiary Designation Instructions

Personally identifiable information such as your Social Security number, date of birth, etc., will not be used for any purpose other than for the administration of the State of Illinois Group Life Insurance Program life insurance benefits.

WHO COMPLETES A BENEFICIARY DESIGNATION

If you are a member of the State of Illinois: a state employee, retiree or certified survivor, you may file a *Beneficiary Designation*. **If no *Beneficiary Designation* is on file, group life insurance benefits will be paid according to the statutory standard sequence in effect on the date of death as explained in the State of Illinois Group Life Insurance Program Booklet.**

Naming standard sequence. If you do not name a beneficiary, we will pay the death benefit according to the standard sequence: 1) your lawful spouse, if living; otherwise 2) your natural or legally adopted child (children) in equal shares, if living; otherwise 3) your parents in equal shares, if living; otherwise 4) your brothers and sisters in equal shares, if living; otherwise 5) the personal representative of your estate. While this may be acceptable to you, please note that it could delay settlement due to issues in attempting to locate and identify family members.

COMPLETING A BENEFICIARY DESIGNATION

Objective. Our objective is to ensure prompt payment of any death benefits available upon your death, as specified by you on the *Beneficiary Designation* form.

Top of form. Your name, address, Social Security number, birth date and telephone number should be typed or printed in ink (not pencil) at the top of the *Beneficiary Designation* form.

Sign and date. After designating a beneficiary or beneficiaries, sign and date the designation at the bottom of the form. Unsigned and/or undated forms will be rejected and returned to you. The form must be dated as of the date signed; forms dated with a future date will be rejected.

Guardian/Conservators. A legal guardian or conservator of the estate may sign a *Beneficiary Designation* form on behalf of a participant. **The guardian or conservator must also submit a copy of the order of guardianship or conservatorship.**

Power of Attorney: A person with Power of Attorney may sign a *Beneficiary Designation* form on behalf of a participant. **They must also submit a copy of the Power of Attorney papers, and the papers must specifically state that the person with Power of Attorney has the right to name and/or change the beneficiaries for the participant.**

Payment progression. Your death benefits will be paid first to your Primary beneficiaries. If some of your Primary beneficiaries die before you, your death benefit will be divided among those Primary Beneficiaries who are still living. Secondary beneficiaries will receive benefits only if no Primary beneficiary survives you.

Questions. If you have questions about this form, please contact Minnesota Life Insurance Company by calling our toll free number 1-888-202-5525.

PLEASE MAIL THE FORM TO MINNESOTA LIFE INSURANCE COMPANY, Springfield Branch Office, PO Box 2327, Springfield, IL 62705-2327. (Only forms with original signatures will be accepted. Facsimiles are not acceptable.)

OPTIONS AVAILABLE FOR DESIGNATING A BENEFICIARY

Equal shares unless otherwise specified. If you name two or more persons as beneficiaries in one category (Primary or Secondary), payment will be made in equal shares to the beneficiaries in that category unless you specify percentages for different beneficiaries. If you specify percentages to be paid to beneficiaries in a category, the percentages in each category must total **100%**. If you choose to designate specific percentages, please write the percentage next to each name.

Per Stirpes distribution. Per stirpes means that the deceased person's issue or lineal descendants take the share of the insurance proceeds that the deceased would have taken had he or she survived. If you wish to specify who shall receive a Primary beneficiary's share if a Primary beneficiary is deceased, (i.e., their children), write "**Per Stirpes**" next to the beneficiary's name. Do not specifically name the descendants.

Naming your estate. If you designate your estate, the distribution of the insurance proceeds will be determined by your will, or Illinois' intestacy laws, if you leave no will. You may want to discuss any possible implications of naming your estate as beneficiary with your attorney or a legal advisor.

If you want to name your estate as beneficiary, simply write the word "**Estate**" on the *Beneficiary Designation* form. Do not include the name of your personal representative or the executor. The benefit will be made payable to your Estate. It will be the responsibility of your executor to distribute the proceeds as outlined in your will.

Naming a trust. You can name a **living trust** or a **testamentary trust** as your beneficiary.

- **Living Trust.** A living trust can be set up at a bank or other financial institution. The implications of setting up a living trust, including the tax consequences, should be discussed with the representatives of the institution where you are setting up the trust.

To name a living trust, you must include the following: 1) the specific name of the trust, 2) the date the trust was created, 3) the name of the trustee, followed by the word "trustee", and 4) the trustee's address.

We recommend that a successor trustee other than yourself be included in your designation of a living trust. Upon your death the successor trustee will be contacted about the death benefits payable.

As an example: **John Doe, as Trustee under the written Trust Agreement dated 01/02/2000; Jane Doe, successor Trustee, 123 Main St., Anytown, IL 65432**

- **Testamentary trust.** A testamentary trust does not come into existence until you die and any preconditions established by your will are met. Usually a will must be probated before a death benefit can be paid to a testamentary trust. You should take this fact into consideration if you decided to name a testamentary trust.

A testamentary trust must include the following: 1) the specific name of the trust, and 2) "created under my last Will and Testament".

As an example: **The Doe Family Trust created in my last Will and Testament**



State of Illinois
Group Life Insurance
Beneficiary Designation

REFER TO INSTRUCTIONS ON PREVIOUS PAGES

TYPE OR PRINT IN INK

MEMBER'S INFORMATION

First name	Middle initial	Last name	Social Security number
Street address			Date of birth
City	State	Zip code	Weekday telephone number

Any benefits payable by the Group Life Insurance Program at my death shall be paid in EQUAL SHARES, unless otherwise specified, to the following Primary beneficiary(ies) who survive me.

P R I M A R Y	Beneficiary name (last, first, middle)	Address Street	Relationship
	Social Security number (optional)	City, state, zip code	Birthdate (mo/day/year)

If all of the aforesaid Primary beneficiary(ies) die prior to my death, the benefit shall be paid in EQUAL SHARES, unless otherwise specified, to the following Secondary beneficiary(ies) who survive me, if any.

S E C O N D A R Y	Beneficiary name (last, first, middle)	Address Street	Relationship
	Social Security number (optional)	City, state, zip code	Birthdate (mo/day/year)

I hereby designate the above named beneficiary(ies). I reserve the right, without consent of the beneficiary, to further change the beneficiary subject to any statutory restrictions. The above designation supersedes all prior designations of beneficiaries I have made.

Member's signature X	Date
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Form must be signed and filed with Minnesota Life Insurance Company to validate designation.

SEND FORM TO: Minnesota Life Insurance Company
Springfield Branch Office
PO Box 2327
Springfield, IL 62705-2327