

Insurance Change Form

Payroll _____

Name _____

Monthly/Hourly/Exempt

SS# _____ - _____ - _____

Percent Employment _____

QUALIFYING CHANGE REASONS: (circle one)

Date of Change _____

- | | |
|---------------------------------|--|
| 10 Benefits Choice | 47 Coordination of spouse's annual election period |
| 30 Birth | 56 Divorce |
| 32 Marriage | 62 Spouse gaining employment |
| 33 Spouse losing employment | 63 Change in Member's Employment Status |
| 35 Dependent becomes ineligible | 65 Dependent becomes eligible for coverage |
| 41 Change not affecting premium | |

Other Reason: _____

ADD OR DELETE DEPENDENT(S)**

[AH CA D3 CF _____]

Effective Date _____

If adding, complete coordination of benefits worksheet at http://www.hr.ilstu.edu/downloads/Benefits_Insurance_Coord_Ben.pdf

- 1) Name _____ M / F SS# _____ Birthdate _____
 Relationship _____ Primary Care Physician Name/# _____
- 2) Name _____ M / F SS# _____ Birthdate _____
 Relationship _____ Primary Care Physician Name/# _____

*** If adding dependents, need to submit copy of marriage certificate and/or birth certificate, copy of spouse's Medicare card, if eligible, copy of adoption papers, or if stepchild, additional documentation as listed in the Benefits Handbook.

CHANGE CARRIER (S)

Effective Date _____

Health Carrier Code _____ Primary Care Physician Name/# _____

Dental: Quality Care Dental Plan

CHANGE LIFE COVERAGE (adding life requires health certificate)

Effective Date _____

OPTIONAL LIFE	INCREASE				DECREASE				ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)	
<input type="checkbox"/> Cancel Opt. Life	<input type="checkbox"/> 1 x basic	<input type="checkbox"/> 2 x basic	<input type="checkbox"/> 3 x basic	<input type="checkbox"/> 4 x basic	<input type="checkbox"/> 5 x basic	<input type="checkbox"/> 6 x basic	<input type="checkbox"/> 7 x basic	<input type="checkbox"/> 8 x basic	<input type="checkbox"/> Cancel AD&D	<input type="checkbox"/> BASIC only (Basic)
	<input type="checkbox"/> 1 x basic	<input type="checkbox"/> 2 x basic	<input type="checkbox"/> 3 x basic	<input type="checkbox"/> 4 x basic	<input type="checkbox"/> 5 x basic	<input type="checkbox"/> 6 x basic	<input type="checkbox"/> 7 x basic	<input type="checkbox"/> 8 x basic		<input type="checkbox"/> COMBINED (Basic & Opt Life)

CHANGE DEPENDENT LIFE COVERAGE (adding life requires health certificate)

Effective Date _____

Spouse Life Add Delete

Child Life (Name(s)) _____ Add Delete

TERMINATE MEMBER

Effective Date _____

08) Termination of Member

01) Death of Member

09) Becomes a dependent of another Member

Transfer: Prog Code _____

CHANGE MARITAL STATUS:

Effective Date _____

Single _____ Married _____

I authorize prevailing premiums (if any) to be deducted from my pay for those coverages I have selected for myself and any dependents. This authorization is to remain in effect until I provide written notice to the contrary and I agree that all future initialed changes on CMS documents are considered as authorization. The statement and answers contained in this application are complete and correct. I agree to abide by all appropriate rules. I agree to furnish any additional information if requested. **My signature confirms that I understand all above options selected and I further authorize ISU Benefits Counselors to initial any CMS documents on my behalf to implement this requested change. This form must be signed by the member.**

Member Signature _____ Date _____

Eligibility Code	Date	Health	Life	%	Dental
T _____					

Coordination of Benefits Worksheet

If you, or any of your dependents who are covered under any State of Illinois health plan, are covered under any other health plan(s) you must provide this information to your Group Insurance Representative to ensure health claims are correctly processed (examples include non-state group health plans, Medicare and Medicaid).

You must complete Section A and Section C below. If you have other insurance, you must also complete Section B **and** provide a copy of the insurance identification card from the other coverage. You must return the completed COB Worksheet to your Group Insurance Representative/Preparer.

SECTION A	
Member Name: _____ Social Security #: _____	
<input type="checkbox"/> I and/or my dependents do NOT have other group health insurance coverage.	
<input type="checkbox"/> I and/or my dependents DO have other group health insurance coverage (you must complete Section B indicating the other coverage). YOU MUST COMPLETE A SEPARATE FORM FOR EACH INSURANCE COMPANY.	
SECTION B	
Insurance Company Name: _____	
Policy Holder Name: _____	
Identification Number: _____	Group Number: _____
Effective Date: _____	Policy Type: Medical ____ Dental ____
Covered Persons	Relationship:
_____	_____
_____	_____
_____	_____
_____	_____
SECTION C	
It is my responsibility to ensure that accurate information is maintained and kept updated regarding my other health/dental insurance. If other coverage is added or terminated for any individuals covered under my State Employees' Group Insurance Program, I must notify the Group Insurance Representative immediately.	
I certify the above information is accurate.	
Member Signature: _____	Date: _____

THIS FORM MUST BE RETURNED TO THE GROUP INSURANCE REPRESENTATIVE AT YOUR AGENCY TO EXPEDITE CLAIM PROCESSING.