FY 2012 BENEFIT CHOICE ELECTION FORM (Instruction Sheet on Back)

Enrollment Period May 1, 2011 – June 17, 2011
Complete This Form Only If Changing Your Benefits

| SECTION A: MEMBER INFORMATION (required) | | | | SSN: | | | | |
|---|--|--|-------------------|---|--------------|-------------|--|--|
| Last Name | First Name | | Phone Numb | | | | | |
| | | | Home: | Work: | | | | |
| SECTION B: OPT OUT/WAIVE or OPT IN (applies to your <u>and</u> your dependents' health, dental, vision <u>and</u> prescription coverage) | | | | | | | | |
| See Instructions on the back for additional documentation requirements Opt OutWaive Coverage if currently enrolled in the Program Opt Out with Financial Incentive – only SERS Annultants | | | | | | | | |
| Opt Out/waive Coverage if our Opt in or Elect Coverage if not of | • | who are not eligible for Medicare can elect this notion | | | | | | |
| SECTION C: HEALTH PLAN ELECTIONS (this election applies to your <u>and your dependents' health coverage)</u> | | | | | | | | |
| Health Plan Election * | | If you selected a managed care plan, you must complete the following: | | | | | | |
| Elect One: | | Carrier Code (2 characters – see map) | | | | | | |
| Quality Care Health Plan (QCHP) | | Carrier/Plan Name Please see addendum | | | | | | |
| ~ Or ~ | \sim Or \sim | | | | | | | |
| (To find the PCP/Provider Identifier, go to the health plan's website.) Managed Care Plan (HMO or OAP) PCP/Provider Identifier | | | | | | | | |
| " If you have another health insurance plan, including Medicare, you must give a copy of your and/or your dependents' other insurance card to your | | | | | | | | |
| GIR. The copy must include the front | and back of th | e card. | | | | | | |
| SECTION D: DENTAL PLAN OPTION (complete ONLY IF CHANGING your current dental coverage election) | | | | | | | | |
| Dental Plan Option - If you elect not to participate in the dental plan, your dental coverage (and any dependent dental coverage) will be terminated (health, vision and prescription coverage will remain active). You may change your dental election only during the Benefit Choice Period. | | | | | | | | |
| □ Tam currently enrolled in the dental plan and would like to drop the □ Tam not currently enrolled in the dental plan and would | | | | | | | | |
| dental coverage (all other coverage remains in force). | | | | | | | | |
| SECTION E: MEMBER OPTIONAL LIFE INSURANCE (complete ONLY IF CHANGING) your life coverage elections) | | | | | | | | |
| | BASIC LIFE ONLY (free - equal to salary) | | | AD&D (Accidental Death & Dismemberment) | | | | |
| LIFE ¹ ☐ BASIC + OPTIONAL (select increment below) | | | □ NO AD&D | □ NO AD&D □ BASIC AD&D only (Equal to Salary) | | | | |
| □ 1xSalary □ 3xSalary □ | | AD&D COMBINED* (Basic Life + Optional Life) * AD&D COMBINED maximum is Basic + 4 times Salary | | | | | | |
| 2 x Salary 4 x Salary 6 x Salary 6 x Salary 7 8 x Salary 7 ADBD COMBINED maximum is Basic + 4 times salary 7 Annultants age 60 and over are not eligible for 5 - 8 times Salary | | | | | | aay | | |
| Annularis age 60 and over are not eigible for 5 – 8 times salary | | | | | | | | |
| SECTION F: DEPENDENT INFORMATION 2 (will have the same health, vision, prescription and dental coverage as the member) | | | | | | | | |
| HEALTH LIFE 1 A (Add) / D (Drop) / Change (C) A D C A D | Name | | SSN (REQUIRED) | Birth Date | Relationship | Sex (MF) | HMO Illinois or Blue Advantage HMO Provider Identifier | |
| | | | | | | | | |
| | | | | | | | | |
| Note: * Statement of Health form required when adding or increasing Member Cotional Life or adding Spouse Life. Form available online. | | | | | | | | |
| Documentation required to <u>add</u> dependents – see specific documentation requirements on the back. Relationship must be spouse, son, daughter, stepchild, adopted child, adjudicated child, legal guardianship or adult veteran child. | | | | | | | | |
| 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 payroil. I will be direct billed. 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 and that if my deductions are not correct I must immediately contact my GIR. Faisification of | | | | | | | | |
| the amounts of the insurance deductions are accurate and that if my deductions are not correct i must immediately contact my GIA. Paistication of the information contained on this form may result in discipline up to and including discharge. | | | | | | | | |
| MEMBER SIGNATURE: DATE: | | | | | | | | |
| GIR/GIP SIGNATURE: | | | | | DATE: | | | |

Benefits Choice FY12 Addendum

| Print Name: | SSN: |
|----------------|--|
| Dependent upon | availability, my choice for Managed Care Plan is listed below in order of preference. |
| Instructions: | list preference in numerical order: 1 st , 2 nd , 3 rd , 4 th |
| | Health Alliance HMO (AH) Health Link OAP (CF) Personal Care OAP (CH) Personal Care HMO (AS) |
| Signature: | Date: |