

Special Enrollment Form – Health Plan Changes **ONLY**

Member Name: _____

SSN: _____ - _____ - _____

Member Telephone Number: _____

You must complete, sign and return this form to SERS, PO Box 19255, Springfield IL 62794-9255 no later than **October 28, 2011**. **This new election will be effective December 1, 2011.** Please note, you may only change your health plan during this Special Enrollment Period; you cannot add or drop dependents or enroll or terminate dental coverage. Deductibles and out of pockets may start over if you change health plans. If you are electing an HMO plan, you must complete the **Primary Care Physician (PCP) Election** section below indicating a Primary Care Physician (PCP) for you and each of your dependents. If you elect the Quality Care Health Plan (QCHP) or one of the Open Access Plans, you need only indicate the health plan, making sure to sign and date the form. **RETURN THIS FORM ONLY IF YOU ARE MAKING A CHANGE IN HEALTH PLANS**

Health Carrier Election (select one – if electing a managed care plan, please ensure the option you elect is available in your area. A map indicating the carriers by county is available on the back of this form.

_____ HMO Illinois (BY)	800/868-9520	800/888-7114 (TDD/TTY)
_____ BlueAdvantage HMO (CI)	800/868-9520	800/888-7114 (TDD/TTY)
_____ HealthLink Open Access Plan (CF)	800/624-2356	800/624-2356, ext. 6280 (TDD/TTY)
_____ PersonalCare HMO (AS)	800/431-1211	217/366-5551 (TDD/TTY)
_____ PersonalCare Open Access Plan (CH)	800/431-1211	217/366-5551 (TDD/TTY)
_____ Health Alliance HMO (AH)	800/851-3379	217/337-8137 (TDD/TTY)
_____ Health Alliance Illinois (BS)	800/851-3379	217/337-8137 (TDD/TTY)
_____ Quality Care Health Plan (QCHP)	800/962-0051	800/526-0844 (TDD/TTY)

Primary Care Physician Election (only complete if you elect an HMO plan)

<u>Member Name</u>	<u>Primary Care Physician Name</u>	<u>Provider Identifier #(contact HMO)</u>
_____	_____	_____
<u>Dependent(s) Name</u>	<u>Primary Care Physician Name</u>	<u>Provider Identifier # (contact HMO)</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

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.

Member Signature _____ Date _____

SERS Group Insurance Rep Signature _____ Date _____

IF MAKING A CHANGE, Please mail this form to:

**SERS
PO Box 19255
Springfield, IL 62794-9255**