GARS
General Assembly Retirement System
srs.illinois.gov

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# Retiree Insurance Form

**This is a required form.** If you fail to submit this form before your retirement annuity date, your coverage will be terminated, (with the exception of basic life insurance coverage). If you submit the form within 60 days of your payable benefit date, you may still elect coverage with an effective date of the first day of the month in which we receive the form. If you fail to return the form or elect not to participate, you will have additional enrollment opportunities during the annual Benefit Choice Period or within 60 days of experiencing a Qualifying Change in Status.

To qualify for the State of IL Group Insurance Program at retirement, you must meet minimum vesting GARS service credit requirements: Tier 1 (6 years), Tier 2 (8 years). If you do not meet these requirements, you do not need to return this form.

## Member/payee information

**Name** *(Last, first, middle)*

**Effective date of retirement** *(MM/DD/YY)*

**Residential address** *(Street, City, State, Zip) (No P.O. Box)*

**SSN (last 4) or Member ID**

**Mailing address** *(if different than residential address) (Street, City, State, Zip)*

**Date of birth**

**Email address**

**Phone number(s)**

(H)

(C)

## Opt-out election

☐ I elect to opt out of the State's group health, vision & prescription drug insurance coverage and understand I will be enrolled with basic life insurance coverage only. I may elect to enroll in dental coverage below.

**Opt-Out Financial Incentive**: To determine if you qualify for the opt-out financial incentive, refer to page 17 of the State of Illinois Retiree, Annuitant & Survivor Handbook: https://www2.illinois.gov/cms/benefits/StateEmployee/Pages/BenefitsBooks.aspx

☐ I elect to opt out of the State Group Insurance Program and take the financial incentive. Please send an incentive packet to me.

Date sent (by email or U.S. mail)_____ GIR initials _____

## Members currently enrolled as a dependent

☐ I have been enrolled as a dependent on my spouse's State-coverage health, dental and vision coverage for at least one year; therefore, I qualify to remain as a dependent on that policy. I understand that by waiving my coverage as a retiree to remain a dependent on my spouse's policy, I only qualify for basic life insurance coverage as a retiree(member).

If you have elected one of the above options, please sign/date the form and return to GARS.

## Health election

☐ I am currently enrolled as an active State employee in the State of IL Group Insurance Program and wish to keep my current health election unless I specify a different plan election below. I have reviewed the current fiscal year's Benefit Choice Booklet found here (https://www2.illinois.gov/cms/benefits/StateEmployee/Pages/BenefitsBooks.aspx).

☐ I am not enrolled in the State of IL Group Insurance Program but wish to enroll as a retiree. I understand coverage will be effective the first day of the month in which the form and all required documents are received or the benefit effective date, whichever is later.

***I have reviewed the available options in my county and select the following health plan I wish to be covered under:***

**Plan name:** _____

*If you selected an HMO available in your county of residence, provide your Primary Care Physician's name, address and/or NPI.*

**Please visit **MyBenefits.Illinois.gov** or contact them at 844-251-1777 for plan options, coverage and enrollment information.*

### Dental election

☐ I elect to be enrolled in dental coverage and understand that premiums will be deducted from my monthly benefit.
☐ I do not wish to enroll in dental coverage. I understand that I can only enroll during future annual Benefit Choice periods.

### Life insurance election

☐ **Basic only:** I am not enrolled in any optional life insurance coverage and understand I will only have the State-paid basic life insurance coverage, which is one times my salary if I'm under age 60, or $5,000 if I'm 60 or older at retirement.
☐ **Basic and Optional:** I elect to keep my current optional life insurance and/or spouse/child life insurance and understand that premiums will be deducted from my monthly benefit.
☐ **Decline Optional Life:** I do not wish to keep my optional life insurance and/or spouse/child life insurance. I understand coverage will terminate on my retirement date.

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### Medicare status

If the Social Security Administration determines you and/or your dependent(s) are Medicare eligible (age 65 and older or under age 65 due to disability or end stage renal disease (ESR)) and you and/or your dependents have not enrolled in Medicare Parts A and B, **you are required to enroll with an effective date the first of the month in which you retire.**

### Check one of the following:

☐ **Not enrolled:** I am under age 65 and not Medicare eligible due to disability or end stage renal disease (ESR).
☐ **Enrolled: Part A Hospital/Part B Medical:** I will provide GARS a copy of my Medicare card and/or my Medicare eligible dependent(s).

***Note: Failure to enroll and maintain enrollment in Parts A and B (when Medicare is the primary insurance payer) results in a reduction of benefits and additional out-of-pocket expenses for medical services.***

**IMPORTANT:** Medicare eligible retirees and annuitants who cover a dependent also enrolled in Medicare Parts A and B are required to enroll in a TRAIL – Total Retiree Advantage Illinois Program Medicare Advantage Prescription Drug Plan (MAPD) within 60 days of the date you receive your enrollment notification. Failure to enroll in an MAPD plan during the 60-day enrollment opportunity will result in loss of State insurance coverage (health, prescription, and vision) and you will only have Medicare Parts A and B. If your coverage is terminated or waived, you can re-enroll in a State-sponsored TRAIL plan throughout the plan year with coverage effective the first of the month following your enrollment request or during the annual TRAIL MAPD Enrollment Period. Your dental coverage, if enrolled, and life insurance coverage will remain in place.

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### Are you electing coverage for eligible dependents?

*(See pages 8-9 of the State Retiree, Annuitant and Survivor Benefits Handbook; go to **https://www2.illinois.gov/sites/SRS/GARS/Resources/Pages/Insurance.aspx** for eligibility requirements.)*

☐ Yes ☐ No

If yes, complete the dependent(s) information below. If your spouse and/or children are not currently covered, please include a copy of your marriage certificate (if adding a spouse) and a copy of the birth certificate for each dependent you want to enroll.

| Dependent name | Social Security number | Date of birth |
|---|---|---|
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### If you and/or your dependents are enrolled in any other group insurance program other than Medicare, please contact your insurance carrier with the information.

*By signing below I certify this information is correct and that I am aware that knowingly making a false statement or falsifying a record in an attempt to defraud GARS is a class 3 felony. I understand that if the GARS Board of Trustees has a reasonable suspicion that an attempt has been made to defraud GARS, it is required to report the matter to the appropriate State's Attorney for investigation.*

**Member signature** _____ **Date** _____