CMS ILLINOIS DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

OPT OUT & OPT IN Election Certificate

Section A: OPT OUT (See Section B to Opt In)

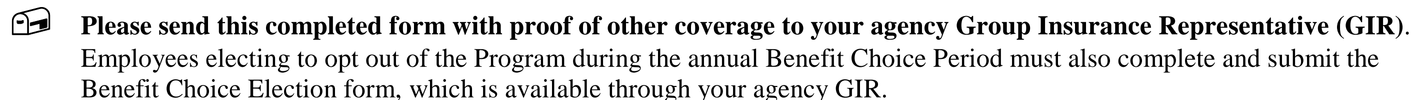
In accordance with Public Act 92-0600, State of Illinois full-time employees, retirees/annuitants and survivors may elect not to participate in the health, dental and vision coverage of the State of Illinois Group Insurance Program (Program). Enrolled dependents of individuals electing to opt out will be terminated on the same date as the Member.

Member Name:___________________________________ **Member SSN:**________________________________

I fully understand and certify the following:

1. The election to opt out of the Program is entirely voluntary. If I elect to opt out, any dependent coverage will also be terminated. The State of Illinois is not responsible for any expenses incurred, for myself or my dependents, on or after my termination date. Furthermore, my covered dependents and I are not eligible for COBRA continuation coverage.
2. I must complete Section A of the Opt Out & Opt In Election Certificate and furnish proof of enrollment in another health benefit plan, either comprehensive major medical or comprehensive managed care, from a source other than the Illinois Department of Central Management Services (Department) including the Local Government Health Plan, Teachers' Retirement Insurance Program or College Insurance Program before my coverage will be terminated. My Program coverage will not be terminated until other eligible coverage is in effect, appropriate documentation has been submitted and such documentation has been approved by the Department. The effective date of opt out is at the discretion of the Department and must comply with Program requirements regarding opt out.
3. I may opt out of the Program only during the annual Benefit Choice period or within 60 days of an eligible Qualifying Change in Status.
4. If my spouse is a Member of any plan administered by the Department including the State of Illinois Group Insurance Program, Local Government Health Plan, Teachers' Retirement Insurance Program or College Insurance Program, I may not enroll as a dependent of my spouse in that plan.
5. If I elect to opt out of the Program, I will continue to be enrolled in the state-paid basic life insurance plan. I understand I am eligible to participate in the optional life insurance plan.
6. At a later date, if I wish to re-enroll in one of the health plans administered by the Department, I understand pre-existing condition limitations may apply if I am unable to provide a Certificate of Creditable Coverage from my previous insurance carrier that reflects that there has been no break in coverage greater than 63-days.
7. To the best of my knowledge, the opt out documentation furnished to substantiate coverage in another health benefit plan is accurate and the policy is currently (or will be, prior to my termination) in force.

Member Signature:____ **Date:** _____/_____/_____



Please send this completed form with proof of other coverage to your agency Group Insurance Representative (GIR). Employees electing to opt out of the Program during the annual Benefit Choice Period must also complete and submit the Benefit Choice Election form, which is available through your agency GIR.

GIR/P Use Only

Proof of comprehensive coverage attached? ☐

Check the appropriate Opt Out eligibility period:

☐ Initial Enrollment (attach completed Initial Enrollment form, CMS-310) ☐ Benefit Choice

☐ Qualifying Change in Status*; Reason Code:_________

* ***Valid Qualifying Changes in Status and corresponding Reason Codes are:***

Marriage (32)	Return from/Entering into Non-pay Status (63)
Change from PT to FT (63)	Spouse now provided with Group Insurance coverage (46)
Spouse Gains Employment (62)	Medicare or Medicaid Eligibility Gained (64)
Retirement (63)	Coordination of Spouse's Election Period (47)

Member Becomes Eligible for Non-State Group Insurance Coverage (65)

____ ____

Group Insurance Representative Signature/Date Telephone Number

____ ____

Agency Name Organizational Processing Code

Coverage Documentation Submitted: ☐ Approved **Opt Out Effective Date:** __________________________

☐ Denied

Section B: OPT IN (See Section A to Opt Out)

State of Illinois full-time employees, retirees/annuitants and survivors who have previously elected not to participate in the health, dental and vision coverage of the State of Illinois Group Insurance Program (Program), may elect to opt back into Program only upon experiencing a qualifying change in status or during the annual Benefit Choice Period.

Member Name:___________________________________ **Member SSN:**________________________________

I fully understand and certify the following:

1. I may opt into the Program only during the annual Benefit Choice period or within 60 days of an eligible Qualifying Change in Status.
2. I must complete Section B of the Opt Out & Opt In Election Certificate and furnish proof of a qualifying change in status (unless election is made during the Benefit Choice Period) before my coverage will be activated. My Program coverage will not be activated until appropriate documentation has been submitted and such documentation has been approved by the Department. The effective date of coverage is at the discretion of the Department and must comply with Program requirements regarding opt in.
3. If I elect to opt into the Program, I will continue to be enrolled in the state-paid basic life insurance plan. I understand I may be eligible to apply for optional life coverage if my qualifying change in status is consistent with the optional life coverage being requested.
4. Upon re-enrolling in one of the health plans administered by the Department, I understand pre-existing condition limitations may apply if I am unable to provide a Certificate of Creditable Coverage with no break in coverage of more than 63-days from my previous insurance carrier.
5. Upon re-enrolling in one of the health plans administered by the Department, I understand that I can elect not to participate in the dental plan and remain enrolled in health and vision. If I elect not to participate in dental, I will not be able to re-enroll in the dental plan until the next Annual Benefit Choice period.

Member Signature:____ **Date:** _____/_____/_____

Employees electing to opt back into the Program during the Benefit Choice Period must complete and submit a Benefit Choice Election form (CMS-350). Employees electing to opt back into the Program due to a Qualifying Change in Status must complete and submit an Initial Enrollment form (CMS-310). Both forms are available through your agency GIR.

Please submit this completed form and appropriate documentation (e.g., proof of loss of other coverage, documentation required to add dependent coverage), along with the Benefit Choice Election form or Initial Enrollment form to your agency Group Insurance Representative (GIR).

GIR/P Use Only

Check the appropriate Opt In eligibility period:

☐ Benefit Choice (attach completed Benefit Choice Election form, CMS-350)

☐ Qualifying Change in Status*: Reason Code:________ (attach completed Initial Enrollment form, CMS-310)

Proof of Qualifying Change in Status attached? ☐

* ***Valid Qualifying Changes in Status and corresponding Reason Codes are:***

Divorce/Legal Separation/Annulment (60)
Medicaid or Medicare Eligibility Loss (64)
Spouse Loses Employment (33)
Coordination of Spouses Annual Election Period (47)
Marriage (32)
Retirement (63)
Death of Spouse (61)
Member Returns to Work from Non-Pay Status (63)
Spouse Loses Eligibility for Group Insurance Coverage (34)
Premium Increase 30% or Greater: Employees Non-State Health Insurance (45)
Premium of Spouse's Employer Increases 30% or Greater, or Coverage Significantly Decreases (45)
Member Loses Eligibility of Non-State Group Insurance Coverage (for reason other than non-payment) (68)

______________________________________ Group Insurance Representative Signature/Date

______________________________________ Telephone Number

______________________________________ Agency Name

______________________________________ Organizational Processing Code

GIR must send completed form and documentation to the CMS Group Insurance Division

For questions call: (217) 558-4978

CMS Only

Coverage documentation submitted: ☐ Approved ☐ Denied

Opt In Effective Date: ____________________ **GID Signature/Date**: ____________________________________