State of Illinois
Department of Central Management Services

LOCAL GOVERNMENT HEALTH PLAN
Member Enrollment Form

Unit Name: ______________________ Member Name: ______________________

MEMBER BIOGRAPHICAL INFORMATION (Please Print or Type)

Member SSN: __________ Temporary SSN: ☐ Yes ☐ No Org. Proc. Code: __________ Eff. Date of Add: __________

Name *(As it appears on SS Card)*

Last: __________ First: __________ Middle: __________

Phone: __________ E-mail: __________

Marital Status: ☐ Single ☐ Married Birthdate: __________ Sex: ☐ Male ☐ Female

Medicare Status: (check one)

☐ 1. Non Medicare
☐ 2. Medicare Eligible 65+
☐ 3. Medicare Ineligible 65+
☐ 4. Medicare Disability
☐ 5. End Stage Renal

If Medicare is 2, 4, 5 complete the following:

Part A (begin date) __________
Part B (begin date) __________
Part D (begin date) __________
Part A Free ☐ Yes ☐ No

If the member has a power of attorney, legal guardian or trustee, please complete the Other Addressee Information if the address is different than members.

Member Residential Address

City/State: __________

ZIP Code: __________ County: __________

Send Mail to this Address? ☐ Yes ☐ No

Other Addressee Information

Name: __________

City/State: __________

ZIP Code: __________ County: __________

Addressee SSN: __________

Relationship: __________

Date of Relationship: __________

Send Mail to this Address? ☐ Yes ☐ No

MEMBER GROUP

Hire Date: __________ Type Enrollee: __________ ☐ Part Time ☐ Full Time

SURVIVORS ONLY

SSN of deceased Member: __________ Relationship to Deceased Member: ☐ Spouse ☐ Child

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Member SSN: ____________

UNIT INFORMATION

Work County Code: ____________

MEMBER HEALTH PLAN

Carrier Code: ________ NPI# (if applicable): ______________ Medical Group/IPA# (if applicable): ________

☐ I elect to waive coverage. Member Initials: ______

I authorize prevailing premiums (if any) to be deducted from my pay or annuity for the coverage I have selected. This authorization is to remain in effect until I provide written notice to the contrary. The statement and answers contained in this application are complete and true. I agree to abide by all appropriate rules and furnish any additional information if requested.

My signature confirms that I understand all above options selected. At all times this form must be signed by the member.

Required Member Signature: ______________________ Date: ____________

I have reviewed and explained all options available to the above member.

Health Plan Representative Signature: ______________________ Date: ____________

Health Plan Representative Phone Number: ______________