

**LOCAL GOVERNMENT HEALTH PLAN (LGHP)**  
**BENEFIT CHOICE ELECTION FORM**  
 ENROLLMENT PERIOD: MAY 1 – MAY 31, 2009  
 Complete This Form Only If Changing Your Benefits

**SECTION A: EMPLOYEE INFORMATION (required)**

SSN: \_\_\_\_\_

Last Name	First Name	Phone Numbers	
		Home:	Work:

**SECTION B: HEALTH PLAN ELECTION (complete only if changing health plans)**

Health Plan Election *	If you selected Managed Care Plan, you must complete the information below. To find the provider identifier, go to the health plan's website. See the instructions on back for more information.
<b>Elect One:</b> Local Care Health Plan (LCHP) <input type="checkbox"/> <p style="text-align: center;">~ Or ~</p> Managed Care Plan (HMO or OAP) <input type="checkbox"/>	Provider Identifier _____ (6 or 10 characters) Carrier Code _____ (2 characters – see page 5) Plan Name _____

\* If you have another health insurance plan, including Medicare, you must give a copy of you and/or your dependent's other insurance card to your HPR. The copy must include the front and back of the card.

**SECTION C: DEPENDENT INFORMATION <sup>1</sup> (dependents will be enrolled with the same coverage that you have)**

NOTE: If you wish to add an adult child due to Public Act 95-0958, DO NOT ENTER YOUR DEPENDENT'S INFORMATION IN THIS SECTION. Instead, you must complete a Special Enrollment Period – Eligibility Certification Statement, available at [www.benefitschoice.il.gov](http://www.benefitschoice.il.gov).

HEALTH			Name	SSN	Birth Date	Relationship <sup>2</sup>	Sex (M/F)	Provider Identifier
A (Add) / D (Drop) / Change (C)	A	D						

Note: <sup>1</sup> Documentation required to add dependents – see specific documentation requirements on the back.  
<sup>2</sup> Relationship must be spouse, son, daughter, stepchild, adopted child, adjudicated child or legal guardian.

This authorization will remain in effect until I provide written notice to the contrary. The information contained in this form is complete and true. I agree to abide by all Local Government Health Plan rules. I agree to furnish additional information requested for enrollment or administration of the plan I have elected.

MEMBER SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

HPR SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**Give completed form to your unit's HPR by May 31, 2009.**