CMS

ILLINOIS
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

STATE OF ILLINOIS GROUP INSURANCE PROGRAM

DEPENDENT COVERAGE CERTIFICATION STATEMENT

EMPLOYEE NAME:_____ **MBR. SSN:** _____

DEPENDENT NAME:_____ **DEP. SSN:** _____

CERTIFICATION EFF. DATE: _____

I certify that the above dependent meets ALL of the qualifications for continued coverage in the dependent category checked below. I have attached the required documentation as stated on the back of this Statement.

Dependent Category ***(Check One)***	**Qualification**
___ Student	Dependent at least age 19 but not yet 23, **and** (1) enrolled as a full-time student in an accredited school, **and** (2) financially dependent upon me, **and** (3) eligible to be claimed as my dependent for income tax purposes.
___ Handicapped	Age 19 or older, **and** (1) continuously disabled from a cause originating prior to age 19, **and** (2) financially dependent upon me, **and** (3) eligible to be claimed as my dependent for income tax purposes.
___ OTHER: Mother, Father, Son, Daughter, Brother Sister, Niece, Nephew Grandparent	Dependent is (1) financially dependent upon me, **and** (2) eligible to be claimed as my dependent for income tax purposes, **and** (3) has either: (3a) received an organ transplant after June 30, 2000, **or** (3b) has been continuously enrolled as a dependent in the State of Illinois Insurance Program (or CNA for university staff) with no break in coverage prior to February 11, 1983.

Please contact your insurance representative for questions regarding continuous coverage or transplant eligibility.
Note: Dependents enrolled in the 'Other' category are not eligible for life insurance coverage.

___ **Terminate Dependent**: My dependent no longer meets the eligibility criteria. By checking the 'Terminate Dependent' line and signing below, I am authorizing the termination of my dependent's coverage.

I understand that it is my responsibility to notify my agency Insurance Representative when and if the above person ceases to meet the qualifications as stated above. I acknowledge and understand that failure to notify the State of changes in my dependent's status will result in termination of coverage retroactive to the last eligible date, recovery of all claim payments and possible forfeiture of premiums paid.

_____ _____

(Member's Signature) (Date) (Insurance Rep's Signature) (Date)

RETURN THIS FORM TO YOUR INSURANCE REPRESENTATIVE

201 E. Madison, Suite 2B, P.O. Box 19208, Springfield, IL, 62794-9208

Qualifying Criteria and Required Documentation
For Student, Handicapped or 'Other' Dependent Categories

STUDENT: **Qualifying Criteria**

a. Unmarried child age 19 through age 22, **and**

b. Enrolled as a full-time student in an accredited school, **and**

c. Financially dependent upon the member, **and**

d. Eligible to be claimed as a dependent for income tax purposes by the member

Required Documentation

1. Verification of enrollment as a full-time student *, **and**
2. Dependent Coverage Certification Statement

* *Examples of documentation include: letter from the Office of the School Registrar, tuition bill marked "paid", copy of enrollment from the university's web-site, abbreviated transcript, copy of grant award or tuition waiver, itemized statement of account.* **Full-time student status must be indicated on the document submitted.**

Note: If your dependent no longer qualifies as a 'Student', he/she may qualify as 'Handicapped' or 'Other' as follows:

HANDICAPPED: **Qualifying Criteria**

a. Unmarried child age 19 or older who is mentally or physically handicapped, **and**

b. Continuously disabled from a cause originating prior to age 19, **and**

c. Financially dependent upon the member, **and**

d. Eligible to be claimed as a dependent for income tax purposes by the member

Required Documentation

1. A diagnosis from a MD with an ICD-9 diagnosis code, **and**
2. Letter from the doctor detailing the dependent's limitations, capabilities and onset of condition, **and**
3. Statement from the Social Security Administration with the Social Security disability determination, **and**
4. Dependent Coverage Certification Statement

OTHER: **Qualifying Criteria**

a. Financially dependent upon the member, **and**

b. Eligible to be claimed as a dependent for income tax purposes by the member, **and** has either:

(1) received an organ transplant after June 30, 2000, or has
(2) been continuously enrolled as a dependent in the State of Illinois Insurance Program (or CNA for university staff) with no break in coverage prior to February 11, 1983.

Required Documentation

1. Dependent Coverage Certification Statement

If you have any questions regarding dependent eligibility or the information provided above, please contact your agency Insurance Representative or CMS Group Insurance Division at (217) 558-4978 or (800) 442-1300.