State of Illinois Group Insurance Program

Domestic Partner Enrollment Form

Member Information (please print):

Name: ____ SSN: __________________________ Date Partnership Began:__________________________

Domestic Partner Information:

Name: _________________________________ SSN: _______________________ Date of Birth: ______________ Provider Identifier:_______________
(complete if enrolled in a managed care plan)

Other Coverage:

Is the Domestic Partner covered by any other health insurance? ☐ Yes ☐ No Effective Date: ___________________________

If yes, name of Insurance Company:____ Insurance Company Policy Number _______________________

Is the Domestic Partner currently covered under a State of Illinois medical plan? ☐ Yes ☐ No

Medicare Information:

Is the Domestic Partner receiving Medicare? ☐ Yes ☐ No (if yes, a copy of the Domestic Partner's Medicare card must be provided to your agency GIR)

If yes, check one: ☐ Part A Eff. Date: __________________ ☐ Part B Eff. Date: ________________
☐ Part A & B Eff. Date: ______________ ☐ Part D Eff. Date: ________________

On what is the Domestic Partner's Medicare eligibility based? ☐ Age ☐ Disability ☐ End Stage Renal Disease

IRS Dependent Tax Status:

Please consult a tax advisor before you certify that the Domestic Partner is a dependent as defined by the Internal Revenue Code. If your answer is YES, you will not be taxed on imputed income for the Domestic Partner's premiums paid by the State of Illinois and contributions made for the Domestic Partner's coverage will be on a pre-tax basis.

Please check one:

☐ No, my Domestic Partner does not qualify as my dependent for Federal income tax purposes.

☐ Yes, my Domestic Partner qualifies as my dependent for Federal income tax purposes (member must provide a copy of the most recent year's tax statement indicating the domestic partner as a dependent with this enrollment form).

Member Signature:____ Date:_____________________ Day Time Phone: (______) _________________

BENEFITS STAFF USE ONLY

GIR Signature:___________________________________ Date:_____________________ Agency Org Proc Code:________________________

☐ Benefit Choice ☐ Initial Enrollment ☐ Qualifying Change in Status, Reason ____

GID Signature:___________________________________ Date:_________________ Effective Date:_________________________ Rel. Code: ________

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