UNIVERSITY OF ILLINOIS
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Part-time Employee Election/Waiver of State Group Insurance Participation

New part-time employees must use this form to either elect or waive participation in the State Employees Group Insurance Program. ***Failure to complete this form will result in automatic enrollment in the Quality Care Health and Dental Plan with no dependent coverage. This form may also be used when*** full-time employees change to part-time status; or current part-time employees reduce their part-time work percentage and insurance premiums increase 30% or greater.

Part-time employees who work at least 50% of a normal work period are eligible to participate in the State Employees' Group Insurance Program.

- A benefits-eligible job that is 100% but less than 9 months is also considered "part-time" for insurance purposes. *
- Participation in health and dental coverage is voluntary.
- Eye-Med vision coverage is provided at no cost to employees participating in the health program.
- Basic life coverage is provided at no cost to employees.

Before making your decision, you should carefully read the following:

1. If you choose to participate in the health, dental and vision coverage, you will be responsible for the state's portion of the health and dental premiums based on the percentage of the time employed (FTE).

Job FTE	Insurance FTE	Percentage of Additional Cost to Employee	Employer Percentage
75%	75%	25%	75%
67%	67%	33%	67%
50%	50%	50%	50%
*100%	50%	50%	50%

2. If you elect **not** to participate in the health/dental plans offered by the State of Illinois, you will not be eligible to enroll in the program until the next Benefit Choice Period (coverage effective July 1 of each year) unless you experience an eligible Qualifying Event.

3. Part-time employees are not eligible to be a dependent on their Illinois state-employed spouse's plan.

4. Provisions and conditions of the Group Insurance Program are applicable if you elect to participate in the Program.

5. You must make a decision within ten (10) calendar days from the effective date of your part-time employment. The effective date of coverage for you and any eligible dependents will be retroactive to your employment date.

Please indicate your choice below by initialing Yes or No and signing:

_____**NO,** I do not wish to participate in the State Employees' Group Insurance Program. I understand that I cannot change this election until the next Benefit Choice Period or until I experience a Qualifying Event, which would allow me to enroll.

_____**YES,** I do want to participate in the coverage initialed below and understand I will be responsible for the coverage premiums.
_____Health, Dental, Vision and Basic Life
_____ Health, Vision and Basic Life, electing not to participate in Dental

UIN:_____
Part-time Employee Signature: _____Date: _____

Group Insurance Representative Signature:_____Date:_____

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UIN:_____

Print Name: _____

Please read the statements below place initials in each box and sign below.

_____ In the event I become a full-time employee in the future, I elected to Opt-Out of state health, dental and vision coverage and have provided a copy of my health insurance card with my name listed or a letter of creditable coverage. I understand this election to Opt Out of health/dental/vision coverage is for the current fiscal year. If I wish to continue this agreement during the next fiscal year, I must make an election during Benefit Choice each year by completing all required forms and providing a current copy of my health insurance card with my name listed to the University Payroll and Benefits Services office or fax to 217-244-3135. Insurance documentation must show the effective date of the coverage and the employee's name.

_____ I understand that if I become a full time employee in the future and have not provided the required documentation to OPT Out or enrolled in a health plan I will be defaulted into Quality Care Health and Dental as a full-time employee. I cannot change this enrollment until the next Benefit Choice Period or until I experience a Qualifying Event, which would allow me to make a change.

DEADLINES: **FAX: 217-244-3135**

10 Days
New employee or newly insurance eligible employee must complete and provided all required information and forms to UPB within 10 calendar days of their hire or insurance eligibility.

Prior to/or on the effective date of new 100% position
Current part-time employee who has elected to waive coverage must provide proof of other insurance coverage and request to Opt Out of state insurance coverage prior to the first day of their 100% job with the university or UPB will default employees into Quality Care Health/Dental plans. To avoid being defaulted into Quality Care Health/Dental plans, employee must enroll in a health plan of their choice or Opt Out prior to the effective date of their new position.

60 Days
Current part-time employee who does not enroll prior to the effective day of their 100% position will be covered by Quality Care Health/Dental plan until an election has made within 60 days of until the Benefit Choice period.

Part-Time Employee Signature: _____ Date: _____
Fiscal Year: _____

Group Insurance Representative Signature:_____Date:_____

Inter Office Documentation of Health Insurance Coverage for Part-time Waived Employee

Fiscal Year OPT- Out Eligibility Verified	Non-State Insurance Carrier Coverage Period	Date Documentation Received By UPB	UPB Staff Verification Sign-Off