PSEBA RECIPIENT REPORTING FORM

Under Section 17 of the Public Safety Employee Benefits Act (820 ILCS 320/17), the Commission on Government Forecasting and Accountability (COGFA) is charged with creating and submitting a report to the Governor and the General Assembly setting forth information regarding recipients and benefits payable under the Public Safety Employee Benefits Act (Act). The Act requires employers providing PSEBA benefits to distribute this form to any former peace officer, firefighter, or correctional officer currently in receipt of PSEBA benefits (PSEBA is also commonly known as "catastrophic injury insurance").

The responses to the questions below will be used by COGFA to compile information regarding the PSEBA benefit for its report. The Act prohibits the release of any personal information concerning the PSEBA recipient and exempts the reported information from the requirements of the Freedom of Information Act (FOIA). The Act requires the PSEBA recipient to complete this form and submit it to the employer providing PSEBA benefits within 60 days of receipt. If the PSEBA recipient fails to submit this form within 60 days of receipt, the employer is required to notify the PSEBA recipient of non-compliance and provide an additional 30 days to submit the required form. Failure to submit the form in a timely manner will result in the PSEBA recipient incurring responsibility for reimbursing the employer for premiums paid during the period the form is due and not filed.

To move through the form, either use your mouse or the "Tab" key. Final instructions for the completed form are at the end of the form in blue.

(1) PSEBA recipient's name:

_____

(2) PSEBA recipient's date of birth:

mm/dd/yyyy

_____

(3) Name of the employer providing PSEBA benefits:

_____

(4) Date the PSEBA benefit first became payable:

mm/dd/yyyy

_____

(5) What was the medical diagnosis of the injury that qualified you for the PSEBA benefit? (brief synopsis of your official medical diagnosis)

_____

(6) Are you currently employed with compensation?

☐ Yes ☐ No

(7) If so, what is the name(s) of your current employer(s)?

_____

(8) Are you or your spouse enrolled in a health insurance plan provided by your current employer or another source?

☐ Yes ☐ No

(9) Have you or your spouse been offered or provided access to health insurance from your current employer(s)?

☐ Yes ☐ No

If you answered yes to question 8 or 9, please provide:

a) Name of the employer:

_____

b) Name of the insurance provider(s):

_____

c) A general description of the type(s) of insurance offered (HMO, PPO, etc.):

(10) Are you or your spouse enrolled in a health insurance plan provided by a current employer of your spouse?

☐ Yes ☐ No

(11) Have you or your spouse been offered or provided access to health insurance provided by a current employer of your spouse?

☐ Yes ☐ No

If you answered yes to question 10 or 11, please provide:

a) Name of the employer:

b) Name of the insurance provider(s):

c) A general description of the type(s) of insurance offered (HMO, PPO, etc. Please see Health Insurance Plan Descriptions below):

Health Insurance Plan Descriptions

HMO (Health Maintenance Organization) - Under this plan, participants must seek doctors, hospitals and all other providers that are covered by the HMO network to get insurance coverage or claim compensation. If a participant goes to a doctor or health provider outside their specific HMO network, they may be responsible for the cost of any services provided. Any visits to a specialist must have a referral from their primary care doctor.

EPO (Exclusive Provider Organization) - This plan functions most like traditional HMOs, but features a nationwide network, instead of the regional HMO network. Also, many plans do not require referrals for participants to consult with specialists.

PPO (Preferred Provider Organization) - Under this plan, participants may seek doctors, hospitals and other health providers either in the PPO network or outside the network. Out-of-network health providers will cost more to the participant than in-network providers, but they are at least partially covered. A referral is not required to see a specialist.

HD(H)P (High Deductible Health Plan) - Under this plan, participants pay lower premiums in exchange for higher deductibles when services are required. Once the deductible is met, coverage applies to 100% of additional costs. These plans may provide access to regional/national networks of health providers or a network of almost all possible providers, depending on the health plan chosen by a participant.

Catastrophic Health Insurance Plan - Under this plan, participants have low premiums and receive coverage for "essential health benefits." However, deductibles for this and similar plans are typically high and "essential health benefits" usually do not cover prescription drugs or immunizations, among other items of interest to participants.

OAP (Open Access Plan) - These plans typically function similar to PPOs and HMOs, in that multiple levels of coverage may be accessed by participants depending on if a health provider is in a particular tier of coverage. A provider in the first tier of coverage may be covered 100%, similar to a HMO, while a provider far away may only be covered in the second or third tier of coverage, at 80% or less for services rendered to participants. Referrals for consultation with specialists are often not required, depending on the plan.

After all questions are answered to the best of your ability, please save this form and send via e-mail to your employer. To save the completed form, choose "File", "Save as". In the "File name" portion of the "Save as" window, please add your full name to the rest of the file name to aid your employer in identifying your file. If unable to save and e-mail form, please print out the form with your responses and return it to your employer.

Clear Form