CHICAGO TRANSIT AUTHORITY—RETIREE HEALTHCARE TRUST
c/o Group Administrators, Ltd. • 915 National Parkway, Suite F, Schaumburg, IL, 60173

RETIREE HEALTH CARE ENROLLMENT FORM

FOR RETIREES, DISABLED PENSIONERS, SURVIVING SPOUSES AND DEPENDENTS

INSTRUCTIONS

- Please complete all sections of this form.
- The pension representative will submit your RHCT application with all required documentation to Group Administrators.
- **Do not send any money with this form.** If your monthly pension is not sufficient to cover your premium cost, you will receive a direct bill for the first month's premium along with your enrollment confirmation.
- After your enrollment form is received, you will be notified if further information is required.
- Retiree refers to retirees and disability pensioners.

PARTICIPANT INFORMATION

Name: _____ _____ _____
First Middle Last

Home Address: _____ _____
Street/Unit Number City/State/Zip Code

Home Phone: _____ Cell phone: _____ Email: _____
(optional) *(optional)*

Date of Birth ____ ____ ____ Date of retirement ____ ____ ____
Month Day Year Month Day Year

Status: ☐ Retiree ☐ Surviving Spouse Social Security #: _____

Gender: ☐ Male ☐ Female Is Spouse a CTA employee? ☐ Yes ☐ No

HEALTHCARE COVERAGE

☐ BCBS PPO ☐ HMO IL ☐ Classic Blue ☐ Decline HC coverage

☐ Retiree Only ☐ Retiree Medicare – Date ___ ____ ____ (You must provide a copy of your Medicare card)

☐ Retiree/Dependent ☐ Dependent Medicare – Date ___ ____ ____ (You must provide a copy of your Medicare card)

☐ Dependent/Survivor ☐ Survivor Medicare – Date ___ ____ ____ (You must provide a copy of your Medicare card)

DENTAL COVERAGE

☐ Retiree Only ☐ Retiree/Dependent ☐ Dependent/Survivor ☐ Decline Dental coverage

Note: Do not check the above box if you are 65 or older at the time of your retirement, you do not qualify for dental coverage.

PAYMENT TYPE

☐ Deducted from check ☐ Direct billing ☐ ACH withdrawal ☐ No deductions

DEPENDANT INFORMATION

Please list only those dependents that are eligible for coverage and that you are currently-enrolling: If you have more than five dependents, please list the additional dependents on a separate sheet of paper. If you are adding your eligible spouse for the first time, you must provide a copy of your marriage license and a copy of his/her Medicare card if he/she is eligible for Medicare. If you are adding any eligible dependent child(ren) for the first time, you must provide copies of their birth certificate(s) or adoption papers, as well as court orders, verification of student status, and military discharge papers when applicable.

Please check all that apply								
Dental Only	Spouse	Son	Daughter	Stepchild	Adopted Child	Name (Last/First/MI)	Birth Date	Social Security #

CERTIFICATION

I authorize Group Administrators to enroll me in the medical and dental plans I have indicated above. I understand that I am responsible for paying the total premium each month and I authorize the CTA Retirement Plan to deduct the premiums from my monthly pension check if it is sufficient to cover the premium. If my monthly pension check is less than the total monthly premium, I understand I will receive a bill and I agree to pay the full premium directly to the CTA Retiree Health Care Trust.

I certify that, to the best of my knowledge, the information provided on this form is true and accurate and that any dependents listed are eligible for coverage under the criteria described in the Enrollment Guide. I understand that I must notify Group Administrators within 30 days of the date any dependent ceases to be eligible for coverage. I understand that enrolling a dependent who is not eligible, or failing to provide notice of ineligibility, may result in the retroactive termination of coverage for me and my dependents, as well as liability for any benefits paid by the Plan on behalf of any ineligible dependent.

Signature _____ Date _____

FOR OFFICE USE ONLY

RPHCT Code:	Storage 1: _____	Single Premium cost:	_____
	Storage 2: _____	Family Premium cost:	_____
	Storage 3: _____	Sub-Total Premium cost:	_____
BSBC ID:	_____	Dental cost:	_____
Effective Date:	_____	Total cost:	_____

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