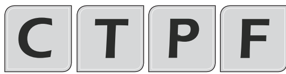

Chicago Teachers' Pension Fund

2017 Health Insurance Enrollment/Change

FORM 350 (REV. 7/2016)

203 North LaSalle Street, Suite 2600 | Chicago, IL 60601-1231
312.641.4464 | *Fax* 312.641.7185 | www.ctpf.org

If you want to enroll for the first time, change plans, add or drop a dependent, complete both sides of this form and return this form and required documentation to CTPF. If you are currently enrolled, you **DO NOT** need to complete a new enrollment form to maintain coverage.

Please complete ALL applicable information. If you do not complete the required information, your application will be returned and your enrollment could be delayed.

SECTION 1: ENROLLMENT INFORMATION

Type of Enrollment & Coverage: Effective Date ____________________			
Enrollment	☐ Initial Enrollment	☐ Open Enrollment	☐ Special Enrollment
Coverage	☐ Retiree only	☐ Retiree +1 dependent	☐ Retireee +2 or more dependents

* **Effective Date:** Plan changes made during Open Enrollment become effective January 1, 2017. If you enroll at a different time call Member Services at 312.641.4464 for an effective date.

SECTION 2: MEMBER INFORMATION

Name: First	M.I	Last	Last 4-digits SSN

Mailing Address Street	Apt. *or* Unit no.

City	State	Zip	E-mail

Member's Birth Date	Telephone number *(with area code)*	☐ Male ☐ Female

SECTION 3: NON-MEDICARE PLANS

If you are 65 or older or enrolled in Medicare you cannot enroll in these plans. Skip this section and see Medicare plans on page 2. All plans include prescription drug coverage. Check box in front of the plan you wish to join.

Blue Cross and Blue Shield

☐ BCBS PPO
☐ BCBS HMO Illinois**

UnitedHealthcare

☐ UHC Choice Plus PPO

****BCBS HMO ILLINOIS ENROLLEES MUST CHOOSE A PROVIDER:** Complete this section if you are enrolling in the BCBS HMO Illinois Health Plan. You and your dependent may choose different IPA/Medical Groups. Enrollment cannot be completed unless you provide an IPA/MG number. If you leave the PCP number blank, BCBS will assign a doctor to you.

BCBS HMO ILLINOIS	PROVIDER'S NAME	IPA/MG NUMBER	PRIMARY CARE PROVIDER (PCP) NUMBER
		See www.bcbsil.com or call 1.800.892.2803 for provider directory	
Member's choice			
Dependent's choice			

SECTION 4: MEDICARE PLANS

Complete this section if you or any of your dependents are enrolled in Medicare Part A and Part B and you wish to join a CTPF plan. Check the box in front of the plan you wish to join and complete Section 5. **You must complete all information or your application will be returned as incomplete and your enrollment could be delayed.** Return the required form(s) and a copy of your Medicare card(s) or Social Security award letter to CTPF.

☐ **Blue Cross and Blue Shield Medicare Advantage PPO with Express Scripts Medicare® (PDP) for CTPF** Complete two forms: this form and the BCBS enrollment form.*

☐ **Humana Group Medicare HMO with Part D Pharmacy** Complete two forms: this form and the Humana enrollment form. *

Call CTPF Member Services for forms: 1.312.641.4464

☐ **AARP Medicare Supplement Plan F (UnitedHealthcare) with Express Scripts Medicare® (PDP) for CTPF.** Complete two forms: this form and the AARP enrollment form. Call AARP at 1.800.392.7537 to request an enrollment kit for the CTPF Group Plan #1089.

SECTION 5: MEDICARE INFORMATION

Complete this section if you or any of your dependents are enrolled in Medicare Part A and Part B. You **MUST** answer questions 1 & 2 and include a copy of the Medicare card(s) or Social Security award letter with your application.

MEDICARE ENROLLEE NAME	MEDICARE NUMBER (SEE CARD)	PART A EFFECTIVE DATE MM/DD/YYYY	PART B EFFECTIVE DATE MM/DD/YYYY

1. Do you have, or have you ever had End Stage Renal Disease (ESRD) or a kidney transplant? ☐ Yes ☐ No

2. Are you eligible for Medicare for a reason other than age? (If yes indicate reason below) ☐ Yes ☐ No

☐ ESRD/kidney transplant ☐ ALS ☐ Disability ☐ other (indicate) ____________________

SECTION 6: DEPENDENT INFORMATION

Indicate if you are adding, changing, or dropping a dependent and complete the required information. Dependents must enroll in the same plan as the member, unless you have a special situation, *(see below)*.

Required Documentation

If you are enrolling a spouse as a dependent, include a copy of your marriage/civil union certificate or tax return with spouse's name. If you are enrolling a child, see the Documentation Requirements in the *Health Insurance Handbook*.

A	D	C	DEPENDENT NAME	SSN	BIRTHDATE *MM/DD/YYYY*	RELATIONSHIP CHILD/ SPOUSE	MALE/ FEMALE
☐	☐	☐					
☐	☐	☐					
☐	☐	☐					

Special Situations: More information in the Couple Coverage section in the *Health Insurance Handbook*

- If one family member is covered by Medicare and the other is not, you must enroll in corresponding plans offered by the same provider. Each enrollee completes a separate application.
- If both applicants are CTPF retirees, complete separate applications; do not enroll your spouse as a dependent.

SECTION 7: AUTHORIZATION AND SIGNATURE

I authorize plan premiums to be deducted from my annuity until I provide written notice of termination. I certify that this information is complete and true. I agree to abide by all rules and furnish additional information if requested.

Member's Signature | **Date**

IMPORTANT – RETURN THIS FORM AND ALL REQUIRED DOCUMENTATION TO CTPF