CTPF
Chicago Teachers' Pension Fund

# 2020 Health Insurance Enrollment/Change

425 S. Financial Place, Suite 1400 | Chicago, IL 60605-1000
312.641.4464 | *Fax* 312.641.7185 | www.ctpf.org

**FORM 350** (REV. 11/2019)

If you want to enroll, change plans, or add/drop a dependent, complete both sides of this form and return with 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. Incomplete information will result in your application being returned and your enrollment could be delayed.**

## SECTION 1: TYPE OF ENROLLMENT & COVERAGE

Plan changes made during Open Enrollment become effective January 1 of the following year. If you enroll at a different time, call Member Services at 312.641.4464 for an effective date. If you are disenrolling, please indicate the date of termination.

**Coverage Level:** ☐ Retiree Only ☐ Retiree +1 Dependent ☐ Retiree +2 or More Dependents

| **Enrollment:** Effective Date _____/_____/_____ | **Disenrollment:** Termination Date _____/_____/_____ |
|---|---|

**Enrollment / Plan Change:** ☐ Initial Enrollment ☐ Open Enrollment ☐ One Time Re-Enrollment** *(Special documentation required)*
☐ Special Enrollment* *(Select a qualifying event below)*

*You may only be enrolled in one plan at a time. Your disenrollment or plan change selection will indicate your desire to cancel your existing CTPF coverage and will be shared with the insurance carrier in order to cancel your CTPF coverage. If your request is received less than 30 days in advance, your request may be effective in the following month.*

**Please select a qualifying event:*

| | |
|---|---|
| ☐ Turning 65 *(eligible for Medicare)* | ☐ Marriage/civil union or divorce/dissolution |
| ☐ Birth, adoption, or legal guardianship | ☐ COBRA coverage period expired *(end of eligibility)* |
| ☐ Canceled by former group plan through no fault of your own | ☐ Other _____ |

** Must provide proof of insurance coverage (medical and prescription drug) as of the beginning of the open enrollment period (October 1), and maintain coverage through December 31 of that year.

## SECTION 2: MEMBER INFORMATION

| **Member Name:** First | M.I. | Last | **Last 4-digits SSN/Member ID:** |
|---|---|---|---|
| **Mailing Address:** Street | Apt. or Unit no. | City | State / Zip |
| **Date of Birth:** *(MM/DD/YYYY)* ☐ **Male** ☐ **Female** | **Email Address:** | | **Telephone Number:** *(with area code)* |

## 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 the box in front of the plan you wish to join.

| **Blue Cross and Blue Shield** | **UnitedHealthcare** |
|---|---|
| ☐ BCBS PPO ☐ BCBS HMO Illinois* | ☐ 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 any dependents 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.

☐ **UnitedHealthcare Group Medicare Advantage (PPO) with Express Scripts Medicare® (PDP)**
Complete this form.

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

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

**PLEASE NOTE:** this plan is only available to those who are 65 or over as of 1/1/2020. If your birth date is 1/2/1955 or after, please select from UHCMA PPO or Humana HMO.

***Call or email CTPF Member Services for forms:** MemberServices@ctpf.org | 312.641.4464

## 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 your 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 pay for Medicare Part A?** ☐ Yes ☐ No *(If yes, you MUST also fill out CTPF MedPay Form 301)*

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

**3. 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 CTPF *Health Insurance Handbook.*

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

**Special Situations:** Find more information in the Couple Coverage section in the CTPF *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**