# HEALTH CARE ENROLLMENT FORM – NON-MEDICARE/MEDICARE ELIGIBLE

**FOR RETIREES, DISABLED PENSIONERS, SURVIVING SPOUSES AND DEPENDENTS**

**2018 OPEN ENROLLMENT**

**For coverage from January 1, 2018 through December 31, 2018**

## *INSTRUCTIONS: ONLY COMPLETE IF YOU ARE CHANGING PLANS*

- Please complete all applicable sections of this form. You must type or print all information.
- Sign the form and return it with all required documentation to Group Administrators using the envelope provided.
- **Do not send any money with this form.** If your monthly pension is not sufficient to cover your premium cost, you will receive a bill for the first month's premium and your enrollment confirmation, separately, in December.
- If you need assistance, contact Group Administrators at 866.997.3821 or rhct@groupadministrators.com.
- **Enrollment forms must be mailed no later than November 15, 2017.**
- After your enrollment form is received, you will be notified if further information is required.

## *RETIREE OR SURVIVING SPOUSE INFORMATION*

Name:_____
First Middle Last

Home Address:_____
Street/Unit Number **(Not P.O. Box)** City/State/Zip Code

Home Phone:_____ Cell Phone: _____Email: _____

Status:☐ Retiree ☐ Surviving Spouse Social Security #: _____ Gender: ☐ M ☐ F

Date of Birth: _____/_____/19_____ Date of Retirement: _____/_____/_____
MM DD YY MM DD YYYY

## MEDICARE HEALTH INSURANCE

If you are Medicare eligible, use your Medicare card to complete this section.

- Fill in these blanks so they match your red, white and blue Medicare card;

**AND**

- Attach a copy of your Medicare card or your letter from Social Security.

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Medicare Claim Number _____

Is Entitled to: Effective Date (mm/yy)

Hospital (Part A) _____ Medical (Part B) _____

## *DEPENDENT INFORMATION*

Please list only those dependents that you are currently enrolling. If you have more than two dependents, please list the additional dependents on a separate sheet of paper. If you are adding your eligible spouse or dependent for the first time, you must provide the necessary documentation. **Please note that the term "spouse" includes legally married spouse, same-sex domestic partner, or civil union partner.** You must provide Medicare Part A and Part B information for each person who is Medicare eligible.

## *SPOUSE OF CTA RETIREE*

Name: _____ _____ _____
First Middle Last

Relationship to Retiree: _____ Gender: ☐ M ☐ F

Date of Birth: _____/_____/19_____ Social Security #: _____
MM DD YY

## SPOUSE MEDICARE HEALTH INSURANCE

If you are Medicare eligible, use your Medicare card to complete this section.

- Fill in these blanks so they match your red, white and blue Medicare card;
  **AND**
- Attach a copy of your Medicare card or your letter from Social Security.

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Medicare Claim Number _____

Is Entitled to: Effective Date (mm/yy)

Hospital (Part A) _____ Medical (Part B) _____

## *ELIGIBLE CHILD*

Name: _____ _____ _____
First Middle Last

Relationship to Retiree: _____ Gender: ☐ M ☐ F

Date of Birth:_____/_____/_____ Social Security #:_____
MM DD YYYY

**IF YOU ALREADY HAVE MEDICARE COVERAGE SKIP THIS PAGE.**

## *MEDICARE ELIGIBLE RETIREE OR SURVIVING SPOUSE*

❑ Yes ❑ No **Do you work?**

❑ Yes ❑ No **Do you have End-Stage Renal Disease (ESRD)?** If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor indicating such, otherwise we may need to contact you to obtain additional information If yes, what is the date of your first dialysis treatment: Date (Month)_____ (Year)_____

❑ Yes ❑ No **Did you become eligible for Medicare because of ESRD <u>and</u> has it been less than 30 months since you became eligible?**

❑ Yes ❑ No **Are you a resident in a long-term care facility, such as a nursing home?**
If yes, provide the following information:
Name of Institution: _____ Phone number: (__) _____
Address: _____ State: _____ Zip: _____

❑ Yes ❑ No **Are you enrolled in your state Medicaid program?**
If yes, provide your Medicaid number: _____

Please check the box if you would prefer Humana to send you information in Spanish. ❑ Spanish

## *MEDICARE ELIGIBLE SPOUSE OF CTA RETIREE*

❑ Yes ❑ No **Do you work?**

❑ Yes ❑ No **Do you have End-Stage Renal Disease (ESRD)?** If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor indicating such, otherwise we may need to contact you to obtain additional information If yes, what is the date of your first dialysis treatment: Date (Month)_____ (Year)_____

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Address: _____ State: _____ Zip: _____

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If yes, provide your Medicaid number: _____

Please check the box if you would prefer Humana to send you information in Spanish. ❑ Spanish

## *IF YOU NEED ANOTHER FORMAT OR LANGUAGE*

Please contact Humana at 1.800.542.2070 (TTY:711) if you need information in another format or language than what is listed above (audio tape, Braille, or large print). Our office hours are Monday – Friday: 9:00 a.m. to 10:00 p.m. CST



Retiree or Surviving Spouse Social Security # _____

## *MEDICAL COVERAGE*

### Declining Medical Coverage

If you are declining medical coverage for yourself, your spouse, and/or your dependent children, please indicate which coverage you are declining. ***Check all that apply.***

- ☐ **I am declining medical coverage for MYSELF at this time**. I understand that if I do this, I only have ***one*** opportunity to enroll – *either* when I lose coverage under another plan, during an annual open enrollment period, *or* when I become eligible for Medicare. I also understand that I must provide documentation indicating that I was covered under another plan immediately prior to the date I want to join this plan. Finally, I understand that if I am a retiree/surviving spouse and I opt out of coverage at any time, I cannot elect coverage for my dependents.
- ☐ **I am declining medical coverage for MY SPOUSE at this time (retirees only)**. I understand that if I do this, my spouse only has ***one*** opportunity to enroll – *either* when he/she loses coverage under another plan, during an annual open enrollment period, in the event of my death, *or* when he/she becomes eligible for Medicare. I also understand that I must provide documentation indicating that he/she was covered under another plan immediately prior to the date he/she wants to join this plan.
- ☐ **I am declining medical coverage for MY ELIGIBLE DEPENDENT CHILDREN at this time**. I understand that if I do this, they only have ***one*** opportunity to enroll – *either* when they lose coverage under another plan, during an annual open enrollment period, in the event of my death (retirees only), *or* when they become eligible for Medicare. I also understand that I must provide documentation indicating that they were covered under another plan immediately prior to the date they want to join this plan.

### Electing Non-Medicare Medical Plan

**I am electing coverage under the following plan for myself and/or my dependents who <u>are not</u> eligible for Medicare:**

☐ BlueCross BlueShield of Illinois PPO ☐ HMO Illinois

### Electing Medicare Medical Plan

**I am electing coverage under the following plan for myself and/or my dependents who <u>are</u> eligible for Medicare:**

☐ Humana Medicare Advantage PPO Plan ☐ Humana Medicare Advantage HMO Plan

### Electing Coverage Level

| | | |
|---|---|---|
| ☐ Retiree Only<br>(includes disabled pensioners) | ☐ Surviving Spouse<br>(includes surviving spouse and dependent children) | ☐ Family<br>(includes retiree, spouse, and/or dependent children) |



Retiree or Surviving Spouse Social Security # _____

## *DENTAL COVERAGE*

### Declining Dental Coverage

If you are declining dental coverage for yourself, your spouse, and/or your dependent children, please indicate which coverage you are declining. ***Check all that apply.***

☐ **I am declining dental coverage for MYSELF at this time**. I understand that if I do this, I will be able to enroll in this plan when I lose coverage under another plan or during the next open enrollment period.

☐ **I am declining dental coverage for MY ELIGIBLE DEPENDENTS at this time**. I understand that if I do this, I will be able to enroll them in this plan when they lose coverage under another plan or during the next open enrollment period.

### Electing Under Age 65 Dental Coverage

**I am electing the following dental coverage for myself and/or my dependent(s) who are under age 65 (or my spouse over age 65, if I, the retiree, am under age 65):**

☐ One Person ☐ Two People ☐ Three or More People

### Electing Over Age 65 Dental Coverage

**I am electing the following dental coverage for myself and/or my dependent(s) who are over age 65: Select one Plan for all family members you are enrolling.**

**Plan:** ☐ High 65 Plan ☐ Low 65 Plan

**Coverage Level**

☐ One Person ☐ Two People ☐ Three or More People

### *AUTHORIZATION, CERTIFICATION, AGREEMENT*– Read this section carefully

I authorize Group Administrators to enroll me in the medical 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 an ineligible dependent in a non-Medicare medical option, or failing to provide notice of ineligibility, may result in the retroactive termination of coverage for me and my dependents who are enrolled in that non-Medicare medical option, as well as liability for any benefits paid by the Plan under that option on behalf of any ineligible dependent.



Retiree or Surviving Spouse Social Security # _____

**By completing this enrollment application, I agree to the following:**

- The Humana Medicare Advantage Plan is a Medicare Advantage plan with prescription drug coverage and has contracts with the Federal government. I can only be in one Medicare Advantage plan at a time and only one Medicare prescription drug plan (PDP) at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health and PDP plan. Once I enroll, I may leave this plan or make changes only at certain times of the year if an enrollment period is available or under certain special circumstances.
- Once I am a member of the Humana Medicare Advantage Plan. I have the right to appeal plan decisions about payment or service if I disagree. I will read the Evidence of Coverage document from Humana when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Original Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border. I may also be disenrolled if I do not pay any applicable plan premiums within the grace period. The effective date of disenrollment is in accordance with Federal requirements.
- I understand that beginning on the date Humana Medicare Advantage PPO Plan coverage begins, using preferred providers can cost less than using non-preferred providers, except for emergency or urgently needed services or out-of-area dialysis services. I understand that I can go to doctors, specialists, or hospitals which are preferred providers or non-preferred providers. I understand that providers must be licensed and eligible to receive payment under the Federal Medicare program and agree to accept the Humana plan. I also understand that I may have to pay more for services that I receive from non-preferred providers. Services authorized by the Humana Medicare Advantage Plan and other services contained in my Humana Medicare Plan Evidence of Coverage document (also known as the member contract or subscriber agreement) will be covered. Without authorization, when required by the plan, **NEITHER MEDICARE NOR THE HUMANA MEDICARE ADVANTAGE PLAN WILL PAY FOR THESE SERVICES**.
- I understand that beginning on the date Humana Medicare Advantage HMO Plan coverage begins, I must use only providers in Humana's HMO network for services to be covered, except for emergency or urgently needed services or out-of-area dialysis services.
- I understand that the providers in the Humana network are independent contractors in private practice and are neither employees nor agents of Humana or its affiliates.

**Release of Information**: By joining this Medicare health plan, I acknowledge that Humana or its affiliates will release my information to Medicare and other plans as is necessary for treatment, payment of claims and health care operations. I also acknowledge that Humana Medicare will release my information to Medicare, who may release it for research and other purposes, which follow all applicable Federal statutes and regulations.

## *SIGNATURES – DESIGNATED ENROLLEES MUST SIGN*

**Retiree or Surviving Spouse**

Signature: _____ Date: _____

If you are the authorized representative, you must sign above and provide the following information

| | |
|---|---|
| Representative's Name | Address |
| Phone Number | Relationship to Enrollee |

**Spouse of CTA Retiree**

Signature: _____ Date: _____

If you are the authorized representative, you must sign above and provide the following information

| | |
|---|---|
| Representative's Name | Address |
| Phone Number | Relationship to Enrollee |

***Make A Copy For Your Records and Return As Per Instructions***



Retiree or Surviving Spouse Social Security # _____