c/o Group Administrators, Ltd.
20 North Martingale Road, Suite 290
Schaumburg, IL 60173
866.997.3821
ctaretirement.org

CHICAGO TRANSIT AUTHORITY—RETIREE HEALTH CARE TRUST
HEALTH CARE ENROLLMENT FORM—NON-MEDICARE/MEDICARE ELIGIBLE
FOR RETIREES, DISABLED PENSIONERS, SURVIVING SPOUSES AND DEPENDENTS

2026 OPEN ENROLLMENT
For coverage from January 1, 2026, through December 31, 2026

INSTRUCTIONS

- Please complete all applicable sections of this form. Type or print all information.
- Sign the form and return it with all required documentation to Group Administrators. A return envelope is provided.
- **The return envelope must be postmarked by November 17, 2025.**
- **Do not send 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.
- For assistance, contact Group Administrators: 866.997.3821 (phone), 855.978.2331 (fax) or rhct@groupadministrators.com.
- 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 a P.O. Box)** City State Zip Code

Home Phone:_____ Mobile Phone: _____Email: _____

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

Gender: ☐ M ☐ F Date of Birth: _____ Retirement Date: _____
MM DD YYYY MM DD YYYY

MEDICARE HEALTH INSURANCE

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

- Enter the information below as it appears on your red, white and blue Medicare card

AND

- Attach a **copy** of your Medicare card or your Medicare eligibility letter from the Social Security Administration.

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

Medicare Claim Number: _____

Is entitled to:

Hospital (Part A) _____ Medical (Part B) _____
Effective Date (mm/yy) Effective Date (mm/yy)

20 North Martingale Road, Suite 290
Schaumburg, IL 60173
866.997.3821
ctaretirement.org

DEPENDENT INFORMATION

Please list only dependents you are currently enrolling. If you have more than two dependents, list additional dependents on a separate sheet of paper and include it with this form. If you are adding your eligible spouse or dependent for the first time, you must provide the necessary documentation. **NOTE: 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: _____ Social Security #: _____
MM/DD/YY

SPOUSE MEDICARE HEALTH INSURANCE

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

- Enter the information below as it appears on your red, white and blue Medicare card
  AND
- Attach a **copy** of your Medicare card or your Medicare eligibility letter from the Social Security Administration.

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

Medicare Claim Number: _____

Is entitled to:
Hospital (Part A) _____ Medical (Part B) _____
Effective Date (MM/YY) Effective Date (MM/YY)

ELIGIBLE CHILD

Name: _____ _____ _____
First Middle Last

Relationship to Retiree: _____ Gender: ☐ M ☐ F

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

Retiree or Surviving Spouse Social Security # _____

20 North Martingale Road, Suite 290
Schaumburg, IL 60173
866.997.3821
ctaretirement.org

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 no longer need regular dialysis, **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 *and* 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's Medicaid program?**
If "Yes," provide your Medicaid number: _____

Please check the box if you would prefer Humana to send you information in Spanish.
(Marque la casilla si prefiere que Humana le envíe información en Español.) ☐ 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 anymore, **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 *and* 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's Medicaid program?**
If "Yes," provide your Medicaid number: _____

Please check the box if you would prefer Humana to send you information in Spanish.
(Marque la casilla si prefiere que Humana le envíe información en Español.) ☐ Spanish

IF YOU NEED ANOTHER FORMAT OR LANGUAGE

Please contact Humana at 800.542.2070 (TTY: 711) if you need information in a format or language other than what is shown above (e.g., audio tape, Braille or large print). Office hours: Monday through Friday, 9 a.m. to 10 p.m. CT.

Retiree or Surviving Spouse Social Security # _____

20 North Martingale Road, Suite 290
Schaumburg, IL 60173
866.997.3821
ctaretirement.org

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 have only **one** opportunity to enroll—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 before 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 has only **one** opportunity to enroll—when he/she loses coverage under another plan, during an annual open enrollment period, if I die, **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 before 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 have only **one** opportunity to enroll—when they lose coverage under another plan, during an annual open enrollment period, if I die (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 before the date they want to join this plan.

Electing a Non-Medicare Medical Plan

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

☐ Aetna Choice Point of Service (POS) II (i.e. PPO) ☐ Aetna Select (i.e. HMO)

Electing a Medicare Medical Plan

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

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

Electing a Coverage Level

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

Retiree or Surviving Spouse Social Security # _____

20 North Martingale Road, Suite 290
Schaumburg, IL 60173
866.997.3821
ctaretirement.org

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 dental coverage for myself and/or my dependent(s). I am under age 65:

☐ One person ☐ Two people ☐ Three or more people

Electing Over-Age-65 Dental Coverage

I am electing dental coverage for myself and/or my dependent(s). I am over age 65:

Plan: ☐ High 65 Plan ☐ Low 65 Plan

Coverage Level

☐ One person ☐ Two people ☐ Three or more people

AUTHORIZATION, CERTIFICATION, AGREEMENT (Read this section carefully)

By signing on the following page, I authorize Group Administrators to enroll me in the benefit plans I have selected above. I understand that I am responsible for paying the total premium each month. I authorize the CTA Retiree Health Care Trust to deduct the premium from my monthly pension checks if these amounts are sufficient to cover the premium. If my monthly pension check is less than the total monthly premium, I understand I will receive a bill for the difference, 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 is no longer eligible for coverage. I understand that if I or my dependents are not eligible for coverage and I enroll myself and/or them, or if I do not provide notice of ineligibility, I will not have coverage for myself and my dependents, and I will be liable for any benefits paid by the Trust on behalf of me and any ineligible dependent.

Retiree or Surviving Spouse Social Security # _____

20 North Martingale Road, Suite 290
Schaumburg, IL 60173
866.997.3821
ctaretirement.org

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 be in only one Medicare Advantage plan at a time and only one Medicare prescription drug plan (PDP) at a time. 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. The Humana plans provide limited emergency Medicare-covered services outside of the U.S. with a $100 deductible, 80% coinsurance and a $25,000 Maximum Annual Benefit or 60 consecutive days, whichever is reached first. 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 that 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 network providers in Humana's HMO service area for services to be covered, except for emergency or urgently needed services or out-of-area dialysis services. The HMO service area includes Cook, DuPage, Kane, Kendall, Lake, McHenry and Will counties only.
- 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, which may release it for research and other purposes that 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 of this form for your records and return it in the enclosed envelope, per the instructions above.

Retiree or Surviving Spouse Social Security # _____