Retirement Plan for CTA Employees / RHCT

55 West Monroe Street/Suite 1950/Chicago, IL 60603
Ph (312) 441-9694/Fax (312) 441-0454
www.ctaretirement.org

Beneficiary Verification Form

Pension # _____

Deceased Participant's Name: _____

Your Name: _____

Your Address: _____

_____
City State Zip Code

_____

Your Telephone Number: _____

Email Address: _____

Your Date of Birth: _____

Your Social Security Number: _____

What was your relationship to the deceased participant? _____

*** Surviving Spouse Only:** If you were enrolled in the Healthcare Plan after July 1, 2009, and married to the retiree for at least one year prior to the date of your separation from employment with the CTA.

Please check one box: [ ] Yes**, I accept Healthcare coverage** [ ] No**, I decline Healthcare coverage**

**** You "MUST" sign and return the healthcare application enclosed even if you choose not to carry coverage.**

_____ _____
Signature **Date**

This information is required to verify that you are the Designated Beneficiary. It is necessary for you to complete, sign, and return this form.