RETIREMENT PLAN FOR CHICAGO TRANSIT AUTHORITY EMPLOYEES

BENEFICIARY VERIFICATION FORM

DECEASED PARTICIPANT'S INFORMATION

First Name | Middle Name | Last Name

Pension Number | Badge Number

BENEFICIARY'S INFORMATION

First Name | Middle Name | Last Name

Street Address | Apt. Number | City | State | Zip Code

Home Phone Number | Mobile Phone Number | Email

Date of Birth | Social Security Number

Relationship to the deceased participant? _____

☐ Non-Spouse Beneficiary ☐ Surviving Spouse Beneficiary

SURVIVING SPOUSE ONLY

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

Check one of the following:

☐ Yes, I accept Healthcare coverage ☐ No, I decline Healthcare coverage

SIGNATURE

You MUST sign and return the healthcare application (RHCT218) 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 with a clear copy of a valid state issued driver's license or an ID to:

Retirement Plan for CTA Employees'
55 W. Monroe St. – Suite 1950
Chicago, IL 60603