CTPF
Chicago Teachers' Pension Fund

2024 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. 8/2023)

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: MEMBER INFORMATION

Member Name: First	M.I.	Last	**Last 4-digits SSN/Member ID:**
Date of Birth: *(MM/DD/YYYY)* ☐ **Male** ☐ **Female**	**Email Address:**		**Telephone Number:** *(with area code)*

SECTION 2: ENROLLMENT & COVERAGE SELECTION

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

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

Plan changes made during Open Enrollment are 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.

Enrollment Type: ☐ Initial Enrollment ☐ Open Enrollment ☐ Special Enrollment* *(Select a qualifying event below)*
☐ One Time Re-Enrollment** *(Proof required)*

** **Proof of medical and prescription coverage** as of October 1st must be provided and coverage must be maintained through December 31st.

I understand that I can only enroll in one plan at a time and that a disenrollment or plan change is an election to cancel my current CTPF coverage. Requests received less than 30 days in advance may not be effective until the following month.

**For Special Enrollment, please check the applicable qualifying event:*

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

SECTION 3: 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* at *www.ctpf.org*.

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

Special Situations: Find more information on Couple Coverage on *www.ctpf.org/health-insurance.*

- 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 4: MEDICARE PLAN ELECTION

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. **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 only.	☐ **Humana Group Medicare (HMO) with Part D Pharmacy*** **Complete two forms:** this form and the Humana enrollment form. **Return both forms to CTPF.**
☐ **Cigna Surround Group Supplement Plan** Complete this form only. **PLEASE NOTE:** this plan is only available to those who turn 65 on or after 1/1/2020. If your birth date is prior to 1/2/1955, please select a different Medicare plan.	☐ **AARP Medicare Supplement Plan F (UHC) with Express Scripts Medicare® (PDP)*** **Complete two forms**: this form **and** the UHC AARP enrollment form. If you live **outside** of Illinois, call UHC at 1.800.392.7537 to request an enrollment kit for the CTPF Group Plan #1089. **Return both forms to CTPF**. **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 a different Medicare plan.

Forms are available on *www.ctpf.org/health-insurance-forms-publications

SECTION 4A: MEDICARE DEPENDENT 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 and 2. You must include copies of the Medicare card or Social Security Award letter for all names listed.

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) ☐ Yes ☐ No

Reason: _____

SECTION 5: NON-MEDICARE PLAN ELECTION

If you are 65 or older, or enrolled in Medicare, you cannot enroll in these plans.

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 6: 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 CTPF procedures and rules and furnish additional information if requested.

Member's Signature: **Date:**

IMPORTANT – RETURN THIS FORM AND ALL REQUIRED DOCUMENTATION TO CTPF