APPLICATION FOR HEALTH BENEFITS

Section 1: Primary Member (Retiree or Surviving Spouse) Information		
Full Name:		
SSN:	Date of birth:	Gender: ☐ M ☐ F
Address:	City:	
State:	ZIP Code:	Home phone: ( )
Email:	Cell phone: ( )	
Emergency contact:	Are you married or in a civil union? ☐ YES ☐ NO	
Relationship:	Are you eligible for Medicare? ☐ YES ☐ NO	
Contact phone: ( )	Do you have End Stage Kidney Disease? ☐ YES ☐ NO	

Section 2: Spouse Information	Fill out this section for a spouse or civil union partner.	
Full Name:		
SSN:	Date of birth:	Gender: ☐ M ☐ F
Medicare eligible? ☐ YES ☐ NO	Does he/she have End Stage Kidney Disease? ☐ YES ☐ NO	

Section 3: Dependent Information	Complete for each eligible dependent child.	
Full Name:		
SSN:	Date of birth:	Gender: ☐ M ☐ F
Medicare eligible? ☐ YES ☐ NO	Disabled? ☐ YES ☐ NO	Does he/she have End Stage Kidney Disease? ☐ YES ☐ NO
Full Name:		
SSN:	Date of birth:	Gender: ☐ M ☐ F
Medicare eligible? ☐ YES ☐ NO	Disabled? ☐ YES ☐ NO	Does he/she have End Stage Kidney Disease? ☐ YES ☐ NO
Full Name:		
SSN:	Date of birth:	Gender: ☐ M ☐ F
Medicare eligible? ☐ YES ☐ NO	Disabled? ☐ YES ☐ NO	Does he/she have End Stage Kidney Disease? ☐ YES ☐ NO
Full Name:		
SSN:	Date of birth:	Gender: ☐ M ☐ F
Medicare eligible? ☐ YES ☐ NO	Disabled? ☐ YES ☐ NO	Does he/she have End Stage Kidney Disease? ☐ YES ☐ NO

Section 4: Plan Selection

Select only **one** of the following plan options.

	With Medicare # enrolled	**Without Medicare** # enrolled
☐ UnitedHealthcare Choice Plan		
☐ UnitedHealthcare Choice Plus Plan		

Section 5: Authorizations

I understand that the benefits I have elected and for which I am eligible are described in my chosen health plan provider's certificate of coverage. I authorize my chosen health plan provider to obtain from health care providers and hospitals the medical records pertaining to me that are necessary for the administration of my contract with my chosen health plan provider. I warrant that the information provided on this form is true, correct, and complete to the best of my knowledge. I authorize my doctors, hospitals, and other health care providers to make available to the claims administrator any and all medical records pertaining to me and/or my spouse and/or my covered dependents for the purpose of reviewing medical treatment, validating and determining benefits, auditing, and/or computing statistics.

I agree to pay all applicable co-payments, deductibles, and coinsurance. If the cost of my health care coverage exceeds my pension check, I agree to pay to the County Employees' and Officers' Annuity and Benefit Fund of Cook County and the Forest Preserve District Employees' Annuity and Benefit Fund of Cook County (collectively, "the Fund") the amount needed to meet the cost of coverage, as explained in the Fund's Health Benefits Handbook.

FOR MEDICARE-ELIGIBLE MEMBERS: I hereby authorize the Centers for Medicare and Medicaid Services (CMS) to furnish my chosen health plan provider (as listed above) affirmation of my and/or my dependent spouse's entitlement to Hospital Insurance Benefits (Part A) and enrollment for Supplementary Medical Insurance Benefits (Part B) under Title XVIII of the Social Security Act. I hereby authorize my chosen health care provider to release to the CMS any medical or other information requested with respect to entitlement to benefits under the Medicare law.

SIGNATURE OF PRIMARY MEMBER **DATE**

OFFICE USE ONLY

Coverage Effective Date	*Office #* 120934 EMP SPO	*Group & Section #*	*Code*
Qualified Change(s)			