



The Cook County Retiree Health Care Program Enrollment Form

To enroll for benefits, complete Sections 1 through 5 of this form. Return this form to the Cook County Pension Fund

SECTION - 1 RETIREE/ANNUITANT MEMBER PERSONAL INFORMATION (PLEASE PRINT)

LAST NAME	FIRST NAME	M.I.
ADDRESS		
CITY	STATE	ZIP CODE
()		
HOME TELEPHONE #	SOCIAL SECURITY #	DATE OF BIRTH
Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have End Stage Kidney Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female Medicare Eligible? <input type="checkbox"/> Yes <input type="checkbox"/> No

*IF "YES" ATTACH A COPY OF YOUR MEDICARE CARD BELOW. IF YOUR SPOUSE ALSO IS ELIGIBLE, ATTACH A COPY OF HIS/HER CARD AS WELL.

SECTION 2 - PLAN SELECTION

Choose one provider only. Please note that members and dependents MUST select the same provider. Also note that you are enrolled in the Caremark prescription plan regardless of your choice of medical care provider. Finally, your and any dependent's enrollment/coverage is subject to satisfaction of ALL eligibility requirements, including any eligibility requirements indicated by the provider.

<input type="checkbox"/> Blue Cross/Blue Shield	MEDICARE OPTION	# enrolled	NON-MEDICARE OPTION	# enrolled
<input type="checkbox"/> HMO Illinois	PPO	_____	PPO	_____
<input type="checkbox"/> UniCare HMO	HMO Illinois	_____	HMO Illinois	_____
	UniCare HMO	_____	UniCare HMO	_____

SECTION 3 - FOR HMO MEMBERS

If you enroll in an HMO, you MUST indicate a primary care facility and/or physician from your provider's directory. (Each covered family member may choose a different primary care physician and /or medical group. If you need a directory, call the Pension Fund Office.) You must agree to seek your health care services according to the rules of membership described by your chosen health care provider. You understand that receiving medical care outside our your provider's plan may not be covered by either your plan or by Medicare.

MEMBER NAME	PCP NAME	SITE NAME	SITE NUMBER
SPOUSE NAME	PCP NAME	SITE NAME	SITE NUMBER
DEPENDENT NAME	PCP NAME	SITE NAME	SITE NUMBER
DEPENDENT NAME	PCP NAME	SITE NAME	SITE NUMBER

SECTION 4 - DEPENDENT INFORMATION

If you plan to enroll any dependents for family coverage, you MUST (1) review the Benefit Eligibility Criteria document, (2) complete the information below for each eligible dependent you wish to enroll and (3) provide the documentation specified in the Benefit Eligibility Criteria document for each eligible dependent you wish to enroll. If you are a new member/annuitant and do NOT wish to enroll any dependents, you MUST complete a Waiver of Insurance Form (available from the Cook County Pension Fund).

DEPENDENT'S LAST NAME	FIRST NAME	SEX	RELATIONSHIP TO YOU	DATE OF BIRTH	SOCIAL SECURITY #	MEDICARE ELIGIBLE?*	DISABLED
		M				YES	YES
		F	SPOUSE			NO	NO
		M				YES	YES
		F	CHILD			NO	NO
		M				YES	YES
		F	CHILD			NO	NO
		M				YES	YES
		F	CHILD			NO	NO

* IF "YES" ATTACH COPY OF YOUR DEPENDENT'S MEDICARE CARD IN THE SPACE PROVIDED IN SECTION 1.

SECTION 5 - AUTHORIZATIONS

Please read all information carefully before signing.

TO BE SIGNED BY ALL MEMBERS: I understand that the benefits for which I have chosen and I am eligible, are described in my chosen health plan provider's certificate of coverage. I authorize my chosen health care provider to obtain from providers of services and hospitals the medical records pertaining to me that are necessary to the administration of my contract with my chosen health care provider. I understand that if I select an HMO, I must receive all of my care from that provider, except for emergency services. I warrant that the information on this form is true, correct and complete to the best of my knowledge. I authorize my doctors, hospital or other medical services providers to make available to the claims administrator any and all medical records pertaining to me and/or my dependents.

I authorize the deduction of the current rate necessary from my pension check for payment of my health plan coverage and agree to pay all applicable co-payments. If the cost of my health care coverage exceeds my pension check, I agree to remit to the administrator of the County of Cook and the Forest Preserve District Retiree Health Care Program any information regarding the medical treatment and benefits for my and/or my dependents for the purpose of reviewing medical treatment, validating and determining benefits, auditing and/or computing statistics.

MEMBER/ANNUITANT SIGNATURE

TO BE SIGNED ONLY BY MEDICARE-ELIGIBLE MEMBERS: I hereby authorize the Centers for Medicare and Medicaid Services (CMS) to furnish my chosen health care provided (as listed above) affirmation of my 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.

MEMBER/ANNUITANT SIGNATURE _____ MEDICARE CLAIM NUMBER _____ DATE _____

SPOUSE/DEPENDENT SIGNATURE _____ MEDICARE CLAIM NUMBER _____ DATE _____

Please return your completed application to the Cook County Pension Fund, 33 N. Dearborn, Suite 1000, Chicago IL 60602

FOR ADMINISTRATIVE USE ONLY			
Coverage Effective Date	Pension Office ID#	Group & Section #	Code
	EMP		
	SPO		
Qualified Change(s)			