

APPLICATION FOR HEALTH BENEFITS



Section 1: Primary Member (Retiree or Surviving Spouse) Information			
Full Name:		HMO Site Number:	
SSN:	Date of birth:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	
Address(Cannot use PO Box):		City:	
State:	ZIP Code:	Home phone: ()	
Email:		Cell phone: ()	
Emergency contact:		Are you married or in a civil union? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Relationship:		Are you eligible for Medicare? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Contact phone: ()		Do you have End Stage Kidney Disease? <input type="checkbox"/> YES <input type="checkbox"/> NO	

Section 2: Spouse Information		Fill out this section for a spouse or civil union partner.	
Full Name:		HMO Site Number:	
SSN:	Date of birth:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	
Medicare eligible? <input type="checkbox"/> YES <input type="checkbox"/> NO	Does he/she have End Stage Kidney Disease? <input type="checkbox"/> YES <input type="checkbox"/> NO		

Section 3: Dependent Information			Complete for each eligible dependent child.		
Full Name:			HMO Site Number:		
SSN:	Date of birth:		Gender: <input type="checkbox"/> M <input type="checkbox"/> F		
Medicare eligible? <input type="checkbox"/> YES <input type="checkbox"/> NO	Disabled? <input type="checkbox"/> YES <input type="checkbox"/> NO	Does he/she have End Stage Kidney Disease? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Full Name:			HMO Site Number:		
SSN:	Date of birth:		Gender: <input type="checkbox"/> M <input type="checkbox"/> F		
Medicare eligible? <input type="checkbox"/> YES <input type="checkbox"/> NO	Disabled? <input type="checkbox"/> YES <input type="checkbox"/> NO	Does he/she have End Stage Kidney Disease? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Full Name:			HMO Site Number:		
SSN:	Date of birth:		Gender: <input type="checkbox"/> M <input type="checkbox"/> F		
Medicare eligible? <input type="checkbox"/> YES <input type="checkbox"/> NO	Disabled? <input type="checkbox"/> YES <input type="checkbox"/> NO	Does he/she have End Stage Kidney Disease? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Full Name:			HMO Site Number:		
SSN:	Date of birth:		Gender: <input type="checkbox"/> M <input type="checkbox"/> F		
Medicare eligible? <input type="checkbox"/> YES <input type="checkbox"/> NO	Disabled? <input type="checkbox"/> YES <input type="checkbox"/> NO	Does he/she have End Stage Kidney Disease? <input type="checkbox"/> YES <input type="checkbox"/> NO			

Section 4: Plan Selection

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

	With Medicare # enrolled	Without Medicare # enrolled
<input type="checkbox"/> Blue Cross Blue Shield – PPO	_____	_____
<input type="checkbox"/> Blue Cross Blue Shield – Blue Advantage HMO	_____	_____
<input type="checkbox"/> Blue Cross Blue Shield – Classic Blue HMO	_____	_____

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 understand that if I select an HMO, I must receive all of my care from my chosen primary care facility or medical group, except for emergency services. 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 # <<Office_No>>	Group & Section #	Code
	EMP SPO		

Qualified Change(s)

