HEALTH PLAN ENROLLMENT APPLICATION

1. Annuitant Information

Last Name		First Name	
Age	Date of Birth	Social Security #	Male ☐ Female ☐
Street Address (cannot be a P.O.Box)			Apartment #
City		State	Zip
Home phone ( )		Cell phone ( )	
E-mail address			
Are you enrolled in Medicare?* YES ☐ NO ☐		Do you have end stage kidney disease?	YES ☐ NO ☐

2. Spouse Information

(only complete this section if enrolling a spouse)

Spouse Last Name		Spouse First Name	
Age	Date of Birth	Social Security #	Male ☐ Female ☐
Is spouse enrolled in Medicare?* YES ☐ NO ☐		Does spouse have end stage kidney disease?	YES ☐ NO ☐

3. Dependent Information

(only complete this section if enrolling children)

Child's Last Name	Child's First Name	M ☐ F ☐	Age
Date of Birth	SS#	Child on Medicare? Y ☐ N ☐	Disabled Dependent? Y ☐ N ☐
Child's Last Name	Child's First Name	M ☐ F ☐	Age
Date of Birth	SS#	Child on Medicare? Y ☐ N ☐	Disabled Dependent? Y ☐ N ☐
Child's Last Name	Child's First Name	M ☐ F ☐	Age
Date of Birth	SS#	Child on Medicare? Y ☐ N ☐	Disabled Dependent? Y ☐ N ☐
Child's Last Name	Child's First Name	M ☐ F ☐	Age
Date of Birth	SS#	Child on Medicare? Y ☐ N ☐	Disabled Dependent? Y ☐ N ☐

***Attach a copy of Medicare card if you or your spouse is enrolled in Medicare**

4. Select a Health Plan

Select only one of the plans below (all family members must enroll in the same plan)	Total number enrolling
UnitedHealthcare **Choice** ☐	
UnitedHealthcare **Choice Plus** ☐	

5. Authorization

I understand the benefits I have elected and for which I am eligible are described in UnitedHealthcare's summary plan description (SPD) and CVS/Caremark's booklet. I authorize UnitedHealthcare and CVS/Caremark to obtain from my health care providers and hospitals the medical records and information pertaining to me that are necessary for the administration of my medical and pharmacy benefits. 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 UnitedHealthcare and CVS/Caremark any and all medical records and information pertaining to me and/or my covered spouse and 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 pre-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 (CCPF) the amount needed to meet the next month's cost of coverage, as listed in the CCPF Health Benefits Plans and Rates flyer.

FOR MEDICARE-ELIGIBLE MEMBERS: I hereby authorize the Centers for Medicare and Medicaid Services (CMS) to furnish UnitedHealthcare and CVS/Caremark 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 Annuitant **Date**

Mail your completed application form to the Cook County Pension Fund at the address below.
Questions? Call CCPF Health Benefits at 312-603-1200 Option #2 or send an email to health@countypension.com

For Office Use Only

Coverage Effective Date	Office #