THE UNIVERSITY OF CHICAGO | HUMAN RESOURCES

Effective: 1/2022

RETIREE MEDICAL PLAN ENROLLMENT FORM

For enrollment into the University of Chicago's Retiree Medical Plan, which provides both medical and prescription drug coverage, complete, sign and submit this "Form" to the HR Benefits Office via fax to 773.834.0996 or scan and email to **retiree@uchicago.edu** within 31 days of your termination date or retirement date (whichever occurs first) or your qualified life event date.
Plan details can be found online at https://humanresources.uchicago.edu/benefits/retireemedicalplan.shtml

Eligibility

You and your eligible dependents may enroll in the Plan if you were either employed by the University:

- Prior to January 1, 2005 in a continuous benefits-eligible position (from hire to termination or retirement date, whichever occurs first) and are at least age 55 on the date of termination or retirement (whichever occurs first), or
- On or after January 1, 2005, are at least age 55 and have completed at least 10 years of continuous benefits-eligible service on the date of termination or retirement (whichever occurs first).

Coverage Level (Check One)

- ☐ One person under age 65
- ☐ One person age 65 or older
- ☐ One person under age 65 or older & one person under age 65
- ☐ Two persons under age 65
- ☐ Two persons age 65 or older
- ☐ Three or more persons all under age 65
- ☐ Three or more persons, including one-person age 65 or older
- ☐ Three or more persons, including two persons age 65 or older

Medicare-eligible retirees (Check One)

☐ Medicare Advantage ☐ Medicare Supplement

Non-Medicare-eligible retirees (Check One)

☐ University of Chicago Health Plan (UCHP) ☐ Blue Cross Blue Shield (HMO Illinois)
☐ Blue Cross Blue Shield (Maroon PPO) ☐ Blue Cross Blue Shield (High Deductible Health Plan Maroon Savings Choice)

Effective Date (Please Print)

Month/Day/Year:

Retiree Information (Please Print)

Retiree Name:		Medicare ID (if applicable):
SSN: XXX-XX-	Hire Date:	Termination or Retirement Date:
Home Address:		
City:	State:	Zip Code:
Home or Cell Phone:		Email Address:

Dependent Information (Please Print)

☐ Spouse ☐ Civil Union Partner ☐ Child ☐ Domestic Partner (Registered with the University on or before December 31, 2016)

Name: Medicare ID (if applicable):

SSN: XXX-XX- Date of Birth: Sex: ☐ Male ☐ Female

Dependent Information (Please Print)

☐ Spouse ☐ Civil Union Partner ☐ Child ☐ Domestic Partner (Registered with the University on or before December 31, 2016)

Name: Medicare ID (if applicable):

SSN: XXX-XX- Date of Birth: Sex: ☐ Male ☐ Female

Signature

I hereby apply for medical and prescription drug coverage under the University of Chicago Retiree Medical Plan. I authorize the release to and use by the claims processor of any medical/prescription drug information necessary to establish the validity of any claim for benefits for myself or on behalf of my eligible dependents. This authorization shall remain valid from the date singed through the term of coverage of the program. A copy of this authorization shall be as valid as the original.

If I have a qualifying life event (e.g. birth/marriage/death) while enrolled; I must notify the Benefits Office within 31 days of the date of the event.

Retiree Signature: Date:

Dependent Information (Please Print)

Name	Dependent Relationship*	SSN	Medicare ID (if applicable)	Date of Birth	Sex
		XXX-XX-			
		XXX-XX-			
		XXX-XX-			
		XXX-XX-			

*Relationship may be one of the following: Spouse, Civil Union Partner, Child, or Domestic Partner (Domestic Partner must have been registered with The University of Chicago by 12/31/2016)