THE UNIVERSITY OF CHICAGO | HUMAN RESOURCES

RETIREE MEDICAL PLAN OPEN ENROLLMENT FORM

Open Enrollment is your once-a-year opportunity to select the medical coverage that is right for you and your family for the following year. To change your current medical plan please complete and return this Open Enrollment form to the Benefits Office via fax to (773) 834-0996 or scan and email to retiree@uchicago.edu by November 15, 2023. Any new elections and all changes will become effective January 1, 2024 and continue through December 31, 2024. If you are not making changes you will remain on your current plan and do not need to complete this form.

Plan details can be found online at https://humanresources.uchicago.edu/benefits/retireemedicalplan.shtml

Eligibility

- If you are eligible for Medicare, you have the choice of a Medicare Advantage Plan or a Medicare Supplement Plan, both administered by Aetna.
- If you are not eligible for Medicare, you have the choice of coverage in one of the four medical plans available to active employees.

Coverage Level (Check One)

☐ One person under age 65
☐ One person age 65 or older
☐ One person 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)

Retiree Information (Please Print)

Retiree Name:		
SSN: XXX-XX-	Medicare ID If applicable #:	
Mailing Address:		
City:	State:	Zip Code:
Home or Cell Phone:	Email Address Required:	

Dependent Information (Please Print) *If you need to add additional dependents, please do so on page 2.*

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

*Domestic Partner must have been registered with The University of Chicago by 12/31/2016

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 claim's 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:

Additional Dependent Information (Please Print)

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

*Domestic Partner must have been registered with The University of Chicago by 12/31/2016