APPLICATION FOR HEALTH BENEFITS COVERAGE

(Print clearly and remember to sign page 2)

ANNUITANT'S INFORMATION

Last Name	First Name	
SSN	Date of Birth	
Street Address		Apartment #
City	State	Zip Code
Home phone#	Cell Phone #	
e-mail address		
Do you have end stage kidney disease? YES ☐ NO ☐		
Are you eligible for Medicare? YES ☐ NO ☐		
Your emergency contact - Last Name	Emergency contact – First Name	
Relationship:	Emergency contact's phone #	

Are you enrolling a Spouse or a Civil Union (CU) partner? YES ☐ NO ☐

Complete next section if enrolling a Spouse or C.U. Partner

Spouse or CU Partner - Last Name		First Name	
SSN	Male ☐ Female ☐	Age	Date of Birth
Is he/she eligible for Medicare? YES ☐ NO ☐			
Does he/she have end stage kidney disease? YES ☐ NO ☐			

Are you enrolling a dependent Child? YES ☐ NO ☐

Complete next section if enrolling a child - use another application for additional child(ren)

Child - Last Name		First Name
SSN	Male ☐ Female ☐	Date of Birth
Disabled? YES ☐ NO ☐	On Medicare? YES ☐ NO ☐ Have end stage kidney disease? YES ☐ NO☐	

SELECT A HEALTH PLAN

A spouse (or civil union partner) and children select the same plan as the Annuitant.

Select only one of the plans below:	**With Medicare** (number enrolled)	**Without Medicare** (number enrolled)
☐ **UnitedHealthcare Choice**		
☐ **UnitedHealthcare Choice Plus**		

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 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 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 (collectively, "the Fund") the amount needed to meet the next month's cost of coverage, as listed in the Fund's 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**

FOR OFFICE USE

Coverage Effective Date	Office #