



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 humanresources.uchicago.edu/benefits/healthwelfare/retireemedical.

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)

- | | |
|---|---|
| <input type="checkbox"/> One person under age 65 | <input type="checkbox"/> Two persons age 65 or older |
| <input type="checkbox"/> One person age 65 or older | <input type="checkbox"/> Three or more persons all under age 65 |
| <input type="checkbox"/> One person under age 65 or older & one person under age 65 | <input type="checkbox"/> Three or more persons, including one-person age 65 or older |
| <input type="checkbox"/> Two persons under age 65 | <input type="checkbox"/> Three or more persons, including two persons age 65 or older |

Effective Date (Please Print)

Month/Day/Year:

Retiree Information (Please Print)

Retiree Name:

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:

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:

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 signed 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:

Benefit Representative Signature:

Date: