THE UNIVERSITY OF CHICAGO | Human Resources

RETIREE MEDICAL PLAN ENROLLMENT FORM

Please complete this form for enrollment into the BlueCross BlueShield PPO medical plan and Express Scripts prescription drug plan and return via fax to 773-834-0996 or scan the form and email to benefits@uchicago.edu. The Retiree Medical Plan is available to employee age 55 or older who were in a continuous benefits-eligible position and were either (1) employed prior to January 1, 2005 or (2) employed after January 1, 2005 and have completed ten years of continuous service. For plan details refer to the Retiree Medical Plan Information Guide available at **humanresources.uchicago.edu/benefits**.

(Please Print and use **BLACK INK ONLY**)

Retiree Information

Last Name	First Name	Middle Initial
Social Security Number	**Date of Birth**	**Gender** ☐ Male ☐ Female
Address		**City, State, Zip**
Home Phone	**Hire Date**	**Retirement Date**
Medicare Number	**Part A Effective Date**	**Part B Effective Date**

Effective Date:

Select Level of Coverage You Want: (Check One Box)

☐ **Yourself Only** ☐ **Yourself + 1 Dependent** ☐ **Yourself + 2 Or More Dependents**

Dependent Information 1

☐ **Spouse** ☐ **Civil Union Partner** ☐ **Domestic Partner** (Registered with the University of Chicago) ☐ **Child**

Last Name	First Name	Middle Initial
Social Security Number	**Date of Birth**	**Gender** ☐ Male ☐ Female
Medicare Number	**Part A Effective Date**	**Part B Effective Date**

Dependent Information 2

☐ **Spouse** ☐ **Civil Union Partner** ☐ **Domestic Partner** (Registered with the University of Chicago) ☐ **Child**

Last Name	First Name	Middle Initial
Social Security Number	**Date of Birth**	**Gender** ☐ Male ☐ Female
Medicare Number	**Part A Effective Date**	**Part B Effective Date**

Select Your Payment Method: (Check One Box) – Direct Bill Administered by CONEXIS

☐ **Monthly Direct Pay** ☐ **FRIP No Pay** ☐ **FRIP Monthly Direct Pay (under age 65 enrollees)**

Signature/Authorization (sign and date below)

I hereby apply for coverage under the University of Chicago Retiree Medical Plan. I authorize the release to and use by the claims processor of any medical 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.

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Retiree Name (Please Print)

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Retiree Signature Date