

Healthcare Election Form

ALL FULL-TIME EMPLOYEES

CHICAGO TRANSIT AUTHORITY

Fax Form To (312) 275-8722 or Mail Form to

(Check all that apply)

HR Benefit Services - 567 W. Lake Street, Chicago, Illinois 60661-1465

☐ New Employee ☐ Adding Dependents ☐ Deleting Dependents ☐ Change in Work Status (To Full-time, Reinstatement)

Name			Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Badge/Payroll #
Last	First	MI	Social Security #	Daytime Phone #
Home Address			Home Phone #	Cell Phone # (optional)
City/State/Zip			Union	Location/Area
Date of Birth (Month/Day/Year)			Date of Hire (Month/Day/Year)	Is Spouse a CTA employee? YES <input type="checkbox"/> NO <input type="checkbox"/>
Name of Spouse		Date of Marriage (Month/Day/Year)	Spouse Social Security #	

Select one of the following options for your medical coverage:

☐ Single or ☐ Family
☐ Cigna PPO/OAP 2 ☐ Cigna PPO/OAP 3

Select one of the following options for your dental coverage:

☐ Single ☐ Family
☐ Humana Dental PPO Plan (CompBenefits)
☐ Humana/CompBenefits DHMO Prestige 75

Civil Partner	Domestic Partner	Spouse	Son	Daughter	Stepchild	Adopted	Please list only dependents that you are adding and/or deleting and provide the HR Benefit Services Department with a copy of certified documentation for each person as required by the plan including: marriage certificate, civil union certificate, birth certificate, adoption papers, and court orders.	
							Name (Last/First/MI)	Birth Date

I authorize the Benefit Services Department to make the changes I have indicated above and authorize the Chicago Transit Authority to deduct my health care premiums on a pre-tax basis under the rules of Section 125 of the Internal Revenue Code.

Signature

Date

☐ Opt-Out Provision

Opting out of Insurance Plans for Year:

I elect not to enroll in the insurance plans provided by the Chicago Transit Authority and have provided a certificate of insurance from my alternate carrier. I understand that I must provide a certificate of insurance every year, during open enrollment, to qualify for the Opt-Out Provision for the following calendar year.

Signature

Date