Healthcare Election Form

PART-TIME EMPLOYEES

CHICAGO TRANSIT AUTHORITY
Fax Form To (312) 275-8722 or Mail Form to
HR Benefit Services - 567 W. Lake Street, Chicago, Illinois 60661-1465

Check all that apply: ☐ New Employee ☐ Change in Spouse/Dependent Information ☐ Adding Dependents ☐ Deleting Dependents

Name Last First MI		Sex: ☐ Male ☐ Female Social Security #	Badge/Payroll # Daytime Phone #
Home Address		Home Phone #	Cell Phone # (optional)
City/State/Zip		Union / Location/Area	Department
Date of Birth (Month/Day/Year)	Date of Hire (Month/Day/Year)	Is Spouse a CTA employee? YES ☐ NO ☐	
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 A ☐ Cigna PPO/OAP B ☐ No Medical

Civil Partner	Domestic Partner	Spouse	Son	Daughter	Stepchild	Adopted	Name (Last/First/MI)	Birth Date

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.

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** _____

Processed by Benefit Services _____