Healthcare Election Form

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

Name Last First MI		Gender: ☐ 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/Parent a CTA employee? YES ☐ NO ☐	Spouse/Parent Name
Name of Spouse	Date of Marriage (Month/Day/Year)	Spouse Social Security #	Spouse/Parent Badge#

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

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.

Civil Partner	Domestic Partner	Spouse	Son	Daughter	Stepchild	Adopted	Name (Last/First/MI)	Gender (M/F)	Birth Date	Social Security Numbers

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**

Processed by Benefit Services _____