CITY COLLEGES® of CHICAGO

Health Insurance Enrollment Form

Retirees and Surviving Spouses

Personal Information –

If you enroll in a HMO medical plan, you MUST indicate your network Primary Care Physician (PCP), Woman's Principal Health Care Provider (WPHCP), if applicable, and their contracting Medical Group name and number. Female members may choose a WPHCP who may be seen for care without referrals from her PCP. However, the PCP and WPHCP must be in the same Medical Group.

SSN#	Last	First	MI

Street Address	City	State	ZIP

Email Address	Home Phone	Cell Phone
	( )	( )

Sex ☐ Male ☐ Female	Marital Status ☐ Married ☐ Not Married	Birth Date (mm/dd/yy)	Hire Date (mm/dd/yy)

PCP's Medical Group #	PCP's Medical Group Name	PCP's Name	WPHCP's Name (must be in same Medical Group as PCP)
__ __ __			

Coverage Election

Select all that apply: ☐ Enroll* ☐ Drop coverage ☐ Change Medical Plans*

***Employees adding an Eligible Dependent during Open Enrollment or because of a qualifying event must provide documentation validating your dependent's status.**

PLAN: ☐ BlueAdvantage HMO ☐ BCBS PPO ☐ Dental ☐ Vision

Family Coverage - Complete Family Information.

HMO Enrollees: Each family member may select a different contracting Medical Group, PCP, and WPHCP (Woman's Principal Health Care Provider). Female members may choose a WPHCP who may be seen for care without referrals from her PCP. However, the PCP and WPHCP must be in the same Medical Group. For additional dependents, please complete another enrollment form.

Coverage	First	Last (if different)	Date of Birth (mm/dd/yy)	Relationship to Participant
Medical: ☐ Add ☐ Drop Dental: ☐ Add ☐ Drop Vision: ☐ Add ☐ Drop	SSN#	PCP's Medical Group Name		PCP's Medical Group # __ __ __
Medical: ☐ Add ☐ Drop Dental: ☐ Add ☐ Drop Vision: ☐ Add ☐ Drop	First	Last (if different)	Date of Birth (mm/dd/yy)	Relationship to Participant
	SSN#	PCP's Medical Group Name		PCP's Medical Group # __ __ __
Medical: ☐ Add ☐ Drop Dental: ☐ Add ☐ Drop Vision: ☐ Add ☐ Drop	First	Last (if different)	Date of Birth (mm/dd/yy)	Relationship to Participant
	SSN#	PCP's Medical Group Name		PCP's Medical Group # __ __ __
Medical: ☐ Add ☐ Drop Dental: ☐ Add ☐ Drop Vision: ☐ Add ☐ Drop	First	Last (if different)	Date of Birth (mm/dd/yy)	Relationship to Participant
	SSN#	PCP's Medical Group Name		PCP's Medical Group # __ __ __
Medical: ☐ Add ☐ Drop Dental: ☐ Add ☐ Drop Vision: ☐ Add ☐ Drop	First	Last (if different)	Date of Birth (mm/dd/yy)	Relationship to Participant
	SSN#	PCP's Medical Group Name		PCP's Medical Group # __ __ __

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Medicare Information

☐ I do not have Medicare coverage	☐ My spouse does not have Medicare coverage
☐ I have Medicare coverage. (Please submit a copy of Medicare card along with this enrollment form.)	☐ My spouse has Medicare coverage. (Please submit a copy of Medicare card along with this enrollment form.)
Health Insurance Claim Account Number - found on the individual Medicare Card	**Health Insurance Claim Account Number** - found on the individual Medicare Card
☐ I have End Stage Renal Disease Start Date: _____ mm dd yy	☐ My spouse has End Stage Renal Disease Start Date: _____ mm dd yy

Other Group Health Insurance Information

– If you or any member of your family have other group health insurance please provide the following.

Insured's Name	Employed By	Birth Date (mm/dd/yy)	Policy Number

Insurance Company Name	Address	City	State	ZIP

I elect coverage under the above-selected Plan(s) on behalf of myself and the above-listed dependents, and understand I am required to make monthly payments to HCSC unless my contribution is deducted from a SURS annuity payment.

I certify that all information furnished by me on this application is true and complete to the best of my knowledge.

I understand that the services listed in the health insurance certificates will be available, subject to the Term and Conditions thereof, beginning with hospital admissions or medical care rendered, on or after the coverage date set by each insurance carrier.

I understand that insurance carrier use or disclosure of individually identifiable health information, whether furnished by me or obtained from other sources such as medical providers, shall be in accordance with the federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).

I understand that I will not have the opportunity to change or cancel my medical plan until the next Open Enrollment period (unless it is within 31 calendar days of a qualifying family status change).

This authorization is to remain in effect until my written notification to the contrary.

Signature of Employee: _____ Date: _____

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