

Healthcare Election Form

Ratified - Bargained - For Employees - Not Represented by the ATU Locals

CHICAGO TRANSIT AUTHORITY
 Fax Form to (312) 275-8722, Email Form to benefits@transitchicago.com or Mail Form to
 HR Benefit Services - 567 West Lake Street, Chicago, Illinois 60661-1465

Check all that apply: Adding Dependents Deleting Dependents
 Change in Work Status (To Full-time, Reinstatement)

| | | | |
|--------------------------------|-----------------------------------|---|-------------------------|
| Name | | Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female | Badge/Payroll # |
| Last | First | MI | 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/Parent a CTA employee? <input type="checkbox"/> YES <input type="checkbox"/> NO | Spouse/Parent Name |
| Name of Spouse | Date of Marriage (Month/Day/Year) | Spouse Social Security # | Spouse/Parent Badge# |

Select from the following options:

| Medical | Dental | Vision |
|---|---|--|
| <input type="checkbox"/> Single <input type="checkbox"/> Family | <input type="checkbox"/> Single <input type="checkbox"/> Family | <input type="checkbox"/> Single <input type="checkbox"/> Family |
| <input type="checkbox"/> Cigna PPO/OAP 2 <input type="checkbox"/> Cigna PPO/OAP 3 | <input type="checkbox"/> Cigna Dental PPO <input type="checkbox"/> Cigna DHMO <input type="checkbox"/> No Dental | <input type="checkbox"/> MetLife Vision <input type="checkbox"/> No Vision |

| | Name (Last/First/MI) | Gender (M/F) | Birth Date | Social Security Numbers |
|---|---|--------------|------------|-------------------------|
| <input type="checkbox"/> Civil Partner | 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. | | | |
| <input type="checkbox"/> Domestic Partner | | | | |
| <input type="checkbox"/> Spouse | | | | |
| <input type="checkbox"/> Son | | | | |
| <input type="checkbox"/> Daughter | | | | |
| <input type="checkbox"/> Stepchild | | | | |
| <input type="checkbox"/> Adopted | | | | |
| <input type="checkbox"/> | | | | |

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. If I should leave the CTA, for any reason, the balance of my indebtedness will be deducted from my last paycheck.

Signature _____ **Date** _____

| | |
|---|--|
| <input type="checkbox"/> Opt-Out Provision | |
| Opting out of Insurance Plans for Year: | I elect not to enroll in the medical 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 _____ |