

Healthcare Election Form

FULL-TIME TEMPORARY EXEMPT 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

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? YES <input type="checkbox"/> NO <input type="checkbox"/>	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 3 <input type="checkbox"/> No Medical	<input type="checkbox"/> Cigna Dental PPO Plan <input type="checkbox"/> No Dental	<input type="checkbox"/> MetLife Vision <input type="checkbox"/> No Vision

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