Please Check Applicable Coverage Please Check Applicable Payment Method

Retiree Only Direct Pay monthly

Retiree + 1 Dependent Direct Pay quarterly

Retiree + 2 or more Dependent FRIP no pay

FRIP monthly pay for under age 65 enrollees

Prior coverage under Maroon Plan \_\_\_\_\_ FRIP quarterly pay for under age 65 enrollees

PLEASE PRINT

|  |  |
| --- | --- |
| Social Security # | Coverage Effective Date |
| Last Name | First Name Middle Initial |
| Street Address Apt# City State Zip | |
| Home Phone Marital Status Sex Date of Birth | |
| Medicare Number Medicare Part A effective date Medicare Part B effective date | |

# Please supply the following information on your covered dependents

PLEASE PRINT

|  |  |
| --- | --- |
| Last Name | First Name Middle Initial Date of Birth |
| Social Security # | Relationship – circle one  Spouse Domestic Partner Son Daughter |
| Medicare Number Medicare Part A effective date Medicare Part B effective date | |

PLEASE PRINT

|  |  |
| --- | --- |
| Last Name | First Name Middle Initial Date of Birth |
| Social Security # | Relationship – circle one  Spouse Domestic Partner Son Daughter |
| Medicare Number Medicare Part A effective date Medicare Part B effective date | |

I hereby apply for coverage under the University of Chicago Retiree Medical Plan. I authorize the release

to and use by the claims processor of any medical information necessary to establish the validity of any claim

for benefits for myself or on behalf of my eligible dependents.

Date Signature of Applicant