



## Voluntary Opt-Out of Benefits under the CTA RHCT ONE-TIME OPT-OUT FORM

As defined by Illinois Public Act 95-0708 and supported by the CTA Retiree Health Care Plan Summary I understand that each eligible person (retiree, disabled pensioner, spouse, dependent child or surviving spouse) may opt out of coverage or drop coverage and return to the Plan **once** after January 1, 2010.

I also recognize that as a retiree, disabled pensioner, or surviving spouse the act of opting-out will cause the subsequent loss of eligibility for my eligible dependent(s) to continue coverage under the Plan while I am opted-out; this will count as my dependent('s') one- time opportunity to opt out.

I further understand that once I have opted-out of the CTA RHCT for the second time, I cannot be reinstated as a participant and that I waive all rights to future insurance benefits from the Plan.

I acknowledge that by signing below I will authorize the Plan to terminate my benefits under the CTA RHCT and I will have utilized my one-time opportunity to opt out of coverage. I realize that I am eligible to return to the Plan **once** in my lifetime; however, the circumstances under which I can be reinstated are limited to Open Enrollment and/or a qualifying event as defined by the CTA RHCT Board of Trustees. In addition to this criteria, I must provide proof of creditable coverage indicating I was insured under another medical plan immediately prior (within 63 days) to my potential reinstatement effective date.

**Choose One**

- Medical Only                       Dental Only                       Medical and Dental

**Choose One**

- Retiree Only                       Spouse Only                       Dependent Only                       Family

\_\_\_\_\_  
**Retiree Name**

\_\_\_\_\_  
**Retiree Signature**

\_\_\_\_/\_\_\_\_/\_\_\_\_  
**Date**

\_\_\_\_\_  
**Spouse Name**

\_\_\_\_\_  
**Spouse Signature**

\_\_\_\_/\_\_\_\_/\_\_\_\_  
**Date**

\_\_\_\_\_  
**Retiree's Social Security Number**

\_\_\_\_\_  
**Effective Date of Opt-Out** (Must be last day of the month)

**Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip Code** \_\_\_\_\_