PHSA – Request for Continuation of Coverage Plan Change

Participant's Name: _____

Last 4 digits SSN: _____ Previous Department.: _____

Address: _____

City/Zip: _____

Home Phone #: _____ Work Phone #: _____

Return to:
City of Chicago
Benefits Management Division
333 S. State Street
Room 400
Chicago, Il 60604
Attn: Judy Landoch

Present Medical Plan: _____

Requested Plan Change for Medical Coverage: (Check one only):

PPO: Blue Cross/Blue Shield PPO _____

Blue Cross/Blue Shield HCA _____

HMO: Unicare Performance HMO _____

Blue Advantage HMO _____

Present Dental Plan: _____

Requested Plan Change for Dental: (check one only)

CompBenefts Dental PPO: _____

CompBenefits Dental HMO: _____

Dependent Addition/Deletion:

Name: _____

Last 4 digits SSN: _____

Birthdate: _____

Participant's Signature: _____ Date: _____

Eligibility requirements of the plan must be met.
A certified copy of the birth certificate or marriage license is required.

Revised: 12/07