# University of Missouri – Retiree Benefits Change Form

| Retiree/Widow(er) Last Name | Retiree/Widow(er) First Name | | MI | Employee ID (not SSN) | |
|---|---|---|---|---|---|
| Residential Street Address (not P.O. Box) | City | State | Zip | Home Phone | Effective Date of Change |

**INSTRUCTIONS**

- Complete only the sections of this form in which changes are requested.
- Dependents/Members defined as covered retiree/widow(er), spouse/sponsored adult dependent or eligible dependent children.
- Return completed form, prior to the requested effective date, to the Office of Human Resources, University of Missouri System, by email, fax, or mail:
  - hrservicecenter@umsystem.edu
  - (573) 882-9603
  - 1000 W. Nifong Blvd., Building 7, Suite 210, Columbia, MO 65211-8220

## Ancillary Insurance Plans

### DENTAL PLAN *(only check one box to make your election changes)*

| Reduce this coverage to the following:<br>*I understand if coverage is reduced it cannot be reinstated at a future date.* | Self Only ☐ | Self + Spouse ☐ | Self + Children ☐ |
|---|---|---|---|

Name(s) of dependent(s) to cancel from dental coverage:
*I understand if coverage is cancelled it cannot be reinstated at a future date.*

1)_____ 3)_____

2)_____ 4)_____

| OR – Cancel coverage <u>for retiree and any covered dependents</u><br>*I understand if coverage is cancelled it cannot be reinstated at a future date.* | ☐ |
|---|---|

### VISION PLAN

| Coverage will continue as currently elected* |
|---|

*Changes to vision coverage may only occur during Retiree Annual Enrollment and is effective January 1 of the following year.

### BASIC LIFE *(check only one box to make your election changes)*

| Reduce this coverage to the following:<br>*I understand if coverage is reduced it cannot be reinstated at a future date.* | Basic Life A (100% paid by UM) ☐ |
|---|---|
| OR – Cancel coverage<br>*I understand if coverage is cancelled it cannot be reinstated at a future date.* | ☐ |

*Basic Life coverage levels reduce automatically with age and coverage ends at age 70 with conversion options.

### ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) *(check only one box to make your election changes)*

| Reduce this coverage to the following:<br>*I understand if coverage is reduced it cannot be reinstated at a future date.* | $10,000 (max if age 75-79)<br>☐ Self ☐ Family | $25,000 (max age if 70-74)<br>☐ Self ☐ Family | $50,000 (max under age 70)<br>☐ Self |
|---|---|---|---|
| OR – Cancel coverage<br>*I understand if coverage is cancelled it cannot be reinstated at a future date.* | ☐ | | |

*AD&D coverage levels reduce automatically with age and coverage ends at age 80.

### DEPENDENT LIFE PLANS *(check one box per plan to make your election changes)*

| 1. Cancel Dependent Life Child* | ☐ |
|---|---|
| 2. Cancel Dependent Life Spouse* | ☐ |

*You will be ineligible to re-enroll in these coverages at a future date if coverage is cancelled.

### SUPPLEMENTAL TERM LIFE *(check box to make your election changes)*

| Cancel this coverage* | ☐ (contact UM System Office of Human Resources, add'l forms required) |
|---|---|

*You will be ineligible to re-enroll in Supplemental Term Life at a future date if coverage is cancelled.

| Retiree/Widow(er) Last Name | Retiree/Widow(er) First Name | MI | Employee ID (not SSN) |
|---|---|---|---|
| | | | |

## Medical Insurance*

### CANCEL MEDICAL PLAN ENROLLMENT FOR RETIREE AND/OR DEPENDENTS

Changes to medical plan enrollment as a retiree, other than reduction/cancellation, may only occur during Retiree Annual Enrollment.

| | |
|---|---|
| Cancel coverage for retiree and/or dependents listed below**<br>(Retiree/Widow(er) must retain coverage in order to continue dependent coverage.)<br>*I understand if coverage is cancelled it cannot be reinstated at a future date.* | ☐ |

Provide the following information only if you want to cancel UM System medical coverage for the listed retiree and/or dependent(s). If there are any additional dependents to list beyond those that will fit on this form, list all information on a separate sheet.

| Name of Covered Member #1 | Retiree or Dependent? | Date of Birth | Cancel UM System Medical Coverage** |
|---|---|---|---|
| | | | ☐ |
| **Signature of Covered Member #1** (REQUIRED)** | | **Date (REQUIRED)** | |

| Name of Covered Member #2 | Retiree or Dependent? | Date of Birth | Cancel UM System Medical Coverage** |
|---|---|---|---|
| | | | ☐ |
| **Signature of Covered Member #2** (REQUIRED)** | | **Date (REQUIRED)** | |

| Name of Covered Member #3 | Retiree or Dependent? | Date of Birth | Cancel UM System Medical Coverage** |
|---|---|---|---|
| | | | ☐ |
| **Signature of Covered Member #3** (REQUIRED)** | | **Date (REQUIRED)** | |

*Retirees are not eligible to add Dependents to their medical plan coverage after the date of retirement, unless the dependent is a Child that experiences a qualifying family status change, then the dependent Child will become a Participant on the first of the month following the date of the qualifying event, provided the Retiree makes written application (including proof of relationship) for such Child within 31 days of the date on which the Child becomes eligible. Contact Um System Office of Human Resources for applicable form.

** Retiree and/or dependent(s) will be **ineligible to re-enroll** in medical insurance at a future date if coverage is cancelled.

## ACKNOWLEDGEMENTS AND AUTHORIZATION

### Acknowledgments:

*I acknowledge that in the event that I or any of my dependents experience a change in eligibility or wish to discontinue coverage under the Plan, it is the retiree's responsibility to contact the UM System Office of Human Resources and complete the appropriate election forms. Coverage will not be terminated retroactively and no retroactive refunds will be processed. Coverage will be terminated effective the first day of the month following the receipt of the completed discontinuation of coverage election forms.*

*For members enrolled in a Medicare Advantage Plan:*

*I understand the Group Medicare Advantage Plans (PPO) are administrated by UnitedHealthcare® on behalf of Centers for Medicaid and Medicare (CMS) and that I will receive a pre-enrollment kit that includes a Statement of Understanding. If I have any questions regarding this material, I understand I should contact UnitedHealthcare® for additional information.*

### Election Authorization

*I hereby make the above elections and authorize the University of Missouri System to deduct/redirect the appropriate amounts from my benefit for the coverages elected. (I also hereby authorize the appropriate providers to release any documentation necessary for treatment, payment and health care operations for mine or my dependents' claims.)*

*I understand it is my responsibility to inform the UM System Office of Human Resources immediately of desired changes in coverage and/or changes in my family status or personal information that affect my benefit coverage or eligibility.*

_____ _____

**Printed Name of Retiree/Widow(er)/Authorized Signee** **Phone Number**

_____ _____

**Signature of Retiree/ Widow(er)/Authorized Signee** **Today's Date**

# University of Missouri – Retiree Beneficiary Designation Information

| Retiree Last Name | Retiree First Name | MI | Employee ID (not SSN) |
|---|---|---|---|
| | | | |

Please complete the following beneficiary designation. If there are any additional beneficiary(ies) beyond those that will fit on this form, list them on a separate sheet.

## Basic Life Insurance Plan Beneficiary(ies)

### Primary

| | | | | |
|---|---|---|---|---|
| **1)** Name | Date of birth | Relationship | Social Security number | Share (%) |
| Address | | | Phone Number | |
| **2)** Name | Date of birth | Relationship | Social Security number | Share (%) |
| Address | | | Phone Number | |

### Contingent

| | | | | |
|---|---|---|---|---|
| **1)** Name | Date of birth | Relationship | Social Security number | Share (%) |
| Address | | | Phone Number | |
| **2)** Name | Date of birth | Relationship | Social Security number | Share (%) |
| Address | | | Phone Number | |

## Supplemental Life Insurance Plan Beneficiary(ies)

### Primary

☐ Beneficiary(ies) same as Life Insurance

| | | | | |
|---|---|---|---|---|
| **1)** Name | Date of birth | Relationship | Social Security number | Share (%) |
| Address | | | Phone Number | |
| **2)** Name | Date of birth | Relationship | Social Security number | Share (%) |
| Address | | | Phone Number | |

### Contingent

| | | | | |
|---|---|---|---|---|
| **1)** Name | Date of birth | Relationship | Social Security number | Share (%) |
| Address | | | Phone Number | |
| **2)** Name | Date of birth | Relationship | Social Security number | Share (%) |
| Address | | | Phone Number | |

## Accidental Death & Dismemberment Insurance Plan Beneficiary(ies)

### Primary

☐ Beneficiary(ies) same as Life Insurance

| | | | | |
|---|---|---|---|---|
| **1)** Name | Date of birth | Relationship | Social Security number | Share (%) |
| Address | | | Phone Number | |
| **2)** Name | Date of birth | Relationship | Social Security number | Share (%) |
| Address | | | Phone Number | |

### Contingent

| | | | | |
|---|---|---|---|---|
| **1)** Name | Date of birth | Relationship | Social Security number | Share (%) |
| Address | | | Phone Number | |
| **2)** Name | Date of birth | Relationship | Social Security number | Share (%) |
| Address | | | Phone Number | |

## Election/Authorization

I hereby designate the above beneficiary(ies) to receive applicable benefits under the plans identified. I hereby revoke any and all previous beneficiary designations.

Retiree signature:_____ Date:_____

**Availability of Summary Health Information**

As a University of Missouri System retiree, the health benefits available to you represent a significant component of your total retirement package. They also provide important protection for you and your family in the case of illness or injury.

Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options.

The SBC, along with a uniform glossary of terms commonly used in health care coverage, is available on the web at: http:/umurl.us/SBC. Paper copies are also available, free of charge, by calling the HR Service Center at 1-800-488-5288.