University of Missouri System

COLUMBIA | KANSAS CITY | ROLLA | ST. LOUIS

2019 Annual Enrollment Retiree Benefits Change Form

Enrollment Period: October 29 – November 9, 2018

Retiree Last Name	Retiree First Name		MI	Employee ID (not SSN)	
Residential Street Address (not P.O. Box)	City	State	Zip	Home Phone	Effective Date **01/01/2019**

Instructions

- Complete only the sections of this form in which changes are requested.
- Return signed and dated form to the University of Missouri System Office of Human Resources by email, fax, or mail:
  - hrservicecenter@umsystem.edu
  - (573) 882-9603
  - 1000 W. Nifong Blvd., Building 7, Suite 210, Columbia, MO 65211-8220
- If you are adding dependent children to your coverage, please provide a copy of the dependent child's proof of age/relationship when submitting this form. Refer to the Proof of Relationship Requirement (PDF available at http://umurl.us/proof) to learn more.

Medical Insurance

Medicare-eligible Member Options

(Please provide a response to each box below only if changing plans for all Medicare-eligible members)

Step 1: Provide the following information about the Medicare-eligible retiree and/or Medicare-eligible dependents. If there are any additional Medicare-eligible dependents beyond those that will fit on this form, list all information for additional dependents on a separate sheet. If no members are Medicare-eligible, continue to **Step 3**.

Medicare-eligible Member Name #1	Retiree or Dependent?	Date of Birth	Effective Date of Medicare Part B*	Does Member have end stage Renal Disease? ** ☐ Yes ☐ No	Medicare Number
Mailing address (if different than above Residential Street Address)	City	State	Zip	Home Phone	
Signature of Medicare-Eligible Member #1 (Required)		Date (Required)			

Medicare-eligible Member Name #2	Retiree or Dependent?	Date of Birth	Effective Date of Medicare Part B*	Does Member have end stage Renal Disease? ** ☐ Yes ☐ No	Medicare Number
Mailing address (if different than above Residential Street Address)	City	State	Zip	Home Phone	
Signature of Medicare-Eligible Member #2 (Required)		Date (Required)			

* You **must** have **Medicare Part A and Part B** to join a Medicare Advantage Plan.

** If yes, the UM System Office of Human Resources or UnitedHealthcare may contact you for additional information.

Step 2: Check the box corresponding to the medical plan election for all **Medicare-eligible members** listed in Step 1.

Medicare Advantage ***Base Plan With Prescription (Plan #13759)***	☐
Medicare Advantage ***Enhanced Plan With Prescription (Plan #13760)***	☐

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

Non-Medicare-eligible Member Options

Step 3: Provide the following information if there are any Non-Medicare-eligible retiree and/or for any Non-Medicare-eligible dependent(s). If you have additional dependents beyond those that will fit on this form, list them on a separate sheet.

Non-Medicare-Eligible Retiree/Dependent Name	Retiree or Dependent?	Date of Birth

Retiree Health PPO Plan*	☐
Healthy Savings Plan**	☐

*This plan is different from the PPO Plan offered to active employees. The active PPO Plan and Custom Network Plans are not available for retiree enrollment. Please refer to http://umurl.us/retireeppo for information about this plan.

** If you wish to enroll in a Health Savings Account (HSA) in conjunction with your Healthy Savings Plan, contact an HSA provider directly and open the HSA of your choice. Your HSA will be an individual account and may require a monthly administration fee.

Ancillary Insurance Plans

Vision Plan

Note: Ancillary plans include dental, vision, life, and accidental death and dismemberment insurance. The only plan restricted to changes during Annual Enrollment is vision. If you would like to make changes to your vision coverage, please do so on this form. If you and/or any dependent(s) are enrolled in other ancillary plans, please use the Retiree Benefits Change Form to reduce or cancel coverage. This form is available at http://umurl.us/retchgpkt, or by contacting the HR Service Center at 1-800-488-5288 or by email request to hrservicecenter@umsystem.edu.

Elect vision coverage*	Self Only	Self + Spouse	Self + Children	Self + Family
	☐	☐	☐	☐
OR – Reduce vision coverage to the following*		Self Only	Self + Spouse	Self + Children
		☐	☐	☐
OR – Cancel vision coverage for all members*			☐	

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

Provide the following information for dependent(s) to be covered under the Vision Plan. If you have additional dependents beyond those that will fit on this form, list them on a separate sheet.

Dependent Name	Relationship	Date of Birth

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

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 | 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.