2024 Annual Enrollment Retiree Benefits Change Form

Enrollment Period: October 23 – November 3, 2023

Retiree / Widow(er) Last Name	Retiree / Widow(er) First Name		MI	Retiree ID (not SSN)	
Residential Street Address (not P.O. Box)	City	State	Zip	Phone Number	Effective Date of Change **January 1, 2024**

INSTRUCTIONS

- **Please complete only the sections of this form in which changes are requested.**
- **During the Annual Enrollment period, use this form to:**
  Section I - Change or cancel medical insurance plans.
  Section II – Add or drop vision, change dental plan option, or reduce/drop coverage in life insurance plans.
  Section III – Signature is required for all changes.
- Dependents/Members are defined as covered retiree or widow(er), spouse/sponsored adult dependent or eligible dependent children.
- Return completed form **no later than November 3, 2023** to the University of Missouri System Office of Human Resources using one of the following methods:
  - Email: hrservicecenter@umsystem.edu
  - Fax: (573) 882-9603
  - Mail: 1105 Carrie Francke Dr, Suite 108, Columbia, MO 65211

ALL REQUESTED CHANGES WILL BE EFFECTIVE JANUARY 1, 2024

Section I:

MEDICAL INSURANCE - *Medical plan changes can only occur during Retiree Annual Enrollment.*

Medicare-eligible Member Options

Step 1: Provide the following information to change the Medicare Advantage Plan choice for a currently enrolled Medicare-eligible retiree or widow(er), and/or any Medicare-eligible dependent(s). All Medicare-eligible members must be enrolled in the same plan.

Medicare-eligible Member Name #1	Does Member Have End Stage Renal Disease? ☐ Yes ☐ No			Date of Birth
Mailing Address (if different than above Residential Street Address)	City	State	Zip	Phone Number
Signature of Medicare-Eligible Member (Required)		**Today's Date (Required)**		

Medicare-eligible Member Name #2	Does Member Have End Stage Renal Disease? ☐ Yes ☐ No			Date of Birth
Mailing Address (if different than above Residential Street Address)	City	State	Zip	Phone Number
Signature of Medicare-Eligible Member (Required)		**Today's Date (Required)**		

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 #13796)***	☐
Medicare Advantage ***Enhanced Plan With Prescription (Plan #13797)***	☐

2024 Annual Enrollment Retiree Benefits Change Form

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

Non-Medicare-eligible Member Options

Step 3: Provide the following information to change the medical plan choice for a currently enrolled non-Medicare-eligible retiree or widow(er), and/or any non-Medicare-eligible dependent(s). All non-Medicare eligible members must be enrolled in the same plan.

Non-Medicare-Eligible Member Name	Relationship to Retiree	Date of Birth
	☐ Retiree ☐ Widow(er) ☐ Spouse, Sponsored Adult Dependent or Child	
	☐ Retiree ☐ Widow(er) ☐ Spouse, Sponsored Adult Dependent or Child	
	☐ Retiree ☐ Widow(er) ☐ Spouse, Sponsored Adult Dependent or Child	

Step 4: Check the box corresponding to the medical plan election for all **non-Medicare-eligible members** listed in Step 3.

Retiree Health PPO Plan*	☐
Retiree 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 Retiree 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.

CANCEL MEDICAL PLAN ENROLLMENT FOR RETIREE AND/OR DEPENDENTS*

Medicare-eligible and Non-Medicare Eligible Members

Cancel coverage for retiree or widow(er) and/or dependent(s) listed below* (Retiree/Widow(er) must retain coverage in order to continue dependent coverage.) ***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 or widow(er) and/or dependent(s).

Name of Covered Member #1	Relationship to Retiree	Date of Birth	Cancel UM System Medical Coverage*
	☐ Retiree ☐ Widow(er) ☐ Spouse, Sponsored Adult Dependent or Child		☐
Signature of Covered Member #1* (REQUIRED)		**Today's Date (REQUIRED)**	

Name of Covered Member #2	Relationship to Retiree	Date of Birth	Cancel UM System Medical Coverage*
	☐ Retiree ☐ Widow(er) ☐ Spouse, Sponsored Adult Dependent or Child		☐
Signature of Covered Member #2* (REQUIRED)		**Today's Date (REQUIRED)**	

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

2024 Annual Enrollment Retiree Benefits Change Form

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

Section II:

Ancillary Insurance Plans

VISION PLAN – *Vision plan coverage changes may only occur during Retiree Annual Enrollment. (check only one box to make your election change)*

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 ☐				

*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

DENTAL PLANS – *A dental plan change may only occur during Retiree Annual Enrollment. Complete only one section below to reduce current Dental Base or Buy Up Plan coverage or to change Dental plans. All dental plan members must be enrolled in the same dental plan option.*

Dental Base Plan

Elect Dental Base Plan Coverage* - Must have current enrollment in Dental Buy Up Plan in order to elect.	Self Only ☐	Self + Spouse ☐	Self + Children ☐	Self + Family ☐

*Provide the following information for dependent(s) to be covered under the Dental Base Plan.

Dependent Name	Relationship	Date of Birth

Reduce current enrollment in Dental Base Plan to the following: *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 base plan: ***I understand if coverage is cancelled, dependent(s) will be ineligible to re-enroll in either dental plan at a future date.*** 1)_____ 2)_____			
OR – **Cancel** coverage for retiree and any covered dependents in dental base plan ***I understand if coverage is cancelled, retiree and/or dependent(s) will be ineligible to re-enroll in either dental plan at a future date.***	☐		

Dental Buy Up Plan

Elect Dental Buy Up Plan Coverage* - Must have current enrollment in Dental Base Plan in order to elect.	Self Only ☐	Self + Spouse ☐	Self + Children ☐	Self + Family ☐

*Provide the following information for dependent(s) to be covered under the Dental Buy Up Plan.

Dependent Name	Relationship	Date of Birth

Reduce current enrollment in Dental Buy Up Plan to the following: *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 buy up coverage: ***I understand if coverage is cancelled, dependent(s) will be ineligible to re-enroll in either dental plan at a future date.*** 1)_____ 2)_____			
OR – Cancel coverage for retiree and any covered dependents in dental buy up plan. ***I understand if coverage is cancelled, retiree and/or dependent(s) will be ineligible to re-enroll in either dental plan at a future date.***	☐		

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

Reduce this coverage to the following: *I understand if coverage is reduced it cannot be reinstated at a future date.*	Basic Life A (100% paid by UM, $0 premium) ☐
OR – Cancel coverage ***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 end of the year in which you turn age 70.

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

Reduce this coverage to the following: *I understand if coverage is reduced it cannot be reinstated at a future date.*	$10,000 (max if age 75-79) ☐ Self ☐ Family	$25,000 (max if age 70-74) ☐ Self ☐ Family	$50,000 (max under age 70) ☐ Self
OR – Cancel coverage ***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 end of the year in which you turn age 80.

ADDITIONAL LIFE INSURANCE *(check only one box to make your election change)*

Reduce this coverage to the following: *I understand if coverage is reduced it cannot be reinstated at a future date.*	1X ☐	2X ☐	Flat Amount (multiple of $5,000, minimum of $20,000) ☐ _____
OR – Cancel coverage ***I understand if coverage is cancelled it cannot be reinstated at a future date.***			☐

DEPENDENT LIFE INSURANCE PLANS *(check only one box per plan to make your election change)*

Child Life*

Reduce this coverage to the following: *I understand if coverage is reduced it cannot be reinstated at a future date.*	$5,000 ☐	$10,000 ☐	$15,000 ☐	$20,000 ☐
OR – Cancel coverage ***I understand if coverage is cancelled it cannot be reinstated at a future date.***				☐

Spouse Life*

Reduce this coverage to the following: *I understand if coverage is reduced it cannot be reinstated at a future date.*	$10,000 ☐	$20,000 ☐	$30,000 ☐	$40,000 ☐
OR – Cancel coverage ***I understand if coverage is cancelled it cannot be reinstated at a future date.***				☐

*Retiree acknowledges that dependent(s) remain eligible for coverage per the plan. It is the responsibility of the retiree to contact the UM Office of Human Resources if a dependent loses eligibility. For eligibility and other information, visit: www.umsystem.edu/totalrewards/retirement/life_insurance

2024 Annual Enrollment Retiree Benefits Change Form

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

Section III:

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.

I acknowledge and agree that this document may be signed by electronic signature, which shall be considered an original signature for all purposes and shall have the same force and effect as an original signature. "Electronic signature" shall include faxed versions of an original signature, electronically scanned and transmitted versions of an original signature, and typed signature in a fillable form or typed signature via Adobe Pro.

_____ _____

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

_____ _____

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

University of Missouri – Retiree Beneficiary Designation Information

Retiree Last Name	Retiree First Name		MI	Retiree ID (not SSN)	
Residential Street Address (not P.O. Box)	City	State	Zip	Phone Number	Effective Date of Change

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. Return completed form to the University of Missouri System Office of Human Resources using one of the following methods:

- Email: hrservicecenter@umsystem.edu
- Fax: (573) 882-9603
- Mail: 1105 Carrie Francke Dr, Suite 108, Columbia, MO 65211

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	

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	

Additional 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	

University of Missouri – Retiree Beneficiary Designation Information

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

Additional Life Insurance Plan Beneficiary(ies) - Continued

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.

I acknowledge and agree that this document may be signed by electronic signature, which shall be considered an original signature for all purposes and shall have the same force and effect as an original signature. "Electronic signature" shall include faxed versions of an original signature, electronically scanned and transmitted versions of an original signature, and typed signature in a fillable form or typed signature via Adobe Pro.

_____ _____

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

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 573-882-2146.