Enrollment Period: October 23 - November 3, 2023

| Retiree / Widow(er) Last Name | Retiree / Widow(er) Firs | t Name | MI | Retiree ID (not SSN) | |
|---|--------------------------|--------|-----|----------------------|---|
| Residential Street Address (not P.O. Box) | City | State | Zip | | 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.
 - <u>Section II</u> Add or drop vision, change dental plan option, or reduce/drop coverage in life insurance plans.
 - <u>Section III</u> 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 Medi retiree or widow(er), and/or any Medicare-eligible dependent | • | | , | 9 | |
| Medicare-eligible Member Name #1 | Does Member Hav | e End Stage Renal [| Date of Birth | | |
| | ☐ Yes ☐ No |) | | | |
| Mailing Address (if different than above Residential Street Address) | City | State | Zip | Phone Number | |
| Signature of Medicare-Eligible Member (Required) | | Today's D | ate (Requi | ired) | |
| Medicare-eligible Member Name #2 Does Member Have End Stage Renal Disease? Date of Birth | | | | | |
| | ☐ Yes ☐ No | | | | |
| Mailing Address (if different than above Residential Street Address) | City | State | Zip | Phone Number | |
| Signature of Medicare-Eligible Member (Required) | Today's D | Today's Date (Required) | | | |
| Step 2: Check the box corresponding to the medical plan ele | ection for all <u>Medic</u> | care-eligible mem | ıbers listed | d in Step 1. | |
| Medicare Advantage Base Plan With Prescription (Plan | #13796) | | | | |
| Medicare Advantage Enhanced Plan With Prescription (| Plan #13797) | | | | |

| 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** Page 1 Page 2 Page | Step 3: Provide the following information to change the medical vidow(er), and/or any non-Medicare-eligible dependent(s). All not Non-Medicare-Eligible Member Name Reti | Relationship to Relationship t | endent or Ch endent or Ch endent or Ch endent or Ch eligible me | ild ild ild ik Plans are no | Date of Birth Date of Birth in Step 3. |
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| Step 3: Provide the following information to change the medical plan choice for a currently enrolled non-Medicare-eligible retiree 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 | Step 3: Provide the following information to change the medical vidow(er), and/or any non-Medicare-eligible dependent(s). All not Non-Medicare-Eligible Member Name Reti | Relationship to Relationship t | endent or Ch endent or Ch endent or Ch endent or Ch eligible me | ild ild ild ik Plans are no | Date of Birth Date of Birth in Step 3. |
| Step 3: Provide the following information to change the medical plan choice for a currently enrolled non-Medicare-eligible retiree 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 | Step 3: Provide the following information to change the medical vidow(er), and/or any non-Medicare-eligible dependent(s). All not Non-Medicare-Eligible Member Name Reti | Relationship to Relationship t | endent or Ch endent or Ch endent or Ch endent or Ch eligible me | ild ild ik Plans are no | Date of Birth Date of Birth in Step 3. |
| 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 | Non-Medicare-Eligible Member Name Reti | Relationship to Relationship t | endent or Ch endent or Ch endent or Ch endent or Ch eligible me | ild ild ik Plans are no | Date of Birth Date of Birth in Step 3. |
| 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** Plan offered to active employees. The active PPO Plan and Custom Network Plans are not available for retire enrollment. Please refer to http://unuruf 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 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* (RetireeMyldow(er) must retain coverage in order to continue dependent coverage.) Inderstand 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) a dependent(s). Name of Covered Member #1 Relationship to Retiree Date of Birth Cancel UM System Retiree Widow(er) Plan of Cancel UM System Plan of Coverage Plan of Cancel UM System Plan of Coverage Plan of Cancel UM System Plan of Cancel UM Syst | Retiree Health PPO Plan* Retiree Health PPO Plan* Retiree Health Savings Plan** This plan is different from the PPO Plan offered to active employees. The prollment. Please refer to http://umurl.us/retireeppo for information about if you wish to enroll in a Health Savings Account (HSA) in conjunction in the HSA of your choice. Your HSA will be an individual account and spen the HSA of your choice. Your HSA will be an individual account and continued the following information only if you want to cancel Understand if coverage is cancelled it cannot be reinstated by the following information only if you want to cancel Undependent(s). Name of Covered Member #1 Retire Sepond Retire Sepond Retire Reti | e | endent or Chendent or Cheligible me | ild mbers listed k Plans are no | in Step 3. |
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| 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** Retiree Healthy Savings Plan ** Pro Plan offered to active employees. The active PPO Plan and Custom Network Plans are not available for retire enrollment. Please reter to http://umunt.us/retireeppe.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 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) alependent(s). Retiree Widow(er) Date of Birth Cancel UM System Retiree Widow(er) Retiree Date of Birth Cancel UM System Provide the following information Provide the following information Provide | Spoi | e, Sponsored Adult Depote Widow(er) e, Sponsored Adult Depote for all non-Medicare- | endent or Ch | mbers listed k Plans are no | □ □ ot available for retiree |
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| 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 retire enrollment. Please refer to http://unuri.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 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) alependent(s). **Name of Covered Member #1** **Relationship to Retiree* **Date of Birth* **Cancel UM System Medical Coverage in Cancel UM System Canc | Retiree Healthy Savings Plan** This plan is different from the PPO Plan offered to active employees. The process of the proce | active PPO Plan and Cu | | contact an H | □ ot available for retiree |
| This plan is different from the PPO Plan offered to active employees. The active PPO Plan and Custom Network Plans are not available for retire 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 sopen 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) adependent(s). **Name of Covered Member #1** **Relationship to Retiree** **Date of Birth** **Cancel UM System Medical Coverage** **General UM System Medical Coverage** ** | This plan is different from the PPO Plan offered to active employees. The process of the process | active PPO Plan and Cเ | | contact an H | ot 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 sopen 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) alependent(s). **Name of Covered Member #1** **Relationship to Retiree** **Date of Birth** **Cancel UM System Medical Coverage** **Date of Covered Member #1** **Relationship to Retiree** **Date of Birth** **Cancel UM System Medical Coverage** **Dependent or Child** **Spouse, Sponsored Adult Dependent or Child** **Spouse, Sponsored Adult Dependent or Child** **Spouse, Sponsored Adult Dependent or Child** **Spouse, Sponsored Member #1** **Today's Date (REQUIRED)** | cancel coverage for retiree or widow(er) and/or dependent(s) (Retiree/Widow(er) must retain coverage in order to continue of Junderstand if coverage is cancelled it cannot be reinstate. Provide the following information only if you want to cancel UN ependent(s). Name of Covered Member #1 | active PPO Plan and Cu | | contact an H | |
| Provide the following information only if you want to cancel UM System medical coverage for the listed retiree or widow(er) adependent(s). Name of Covered Member #1 Relationship to Retiree Date of Birth Cancel UM System Medical Coverage | Provide the following information only if you want to cancel UN ependent(s). Name of Covered Member #1 Retir | sted below* | | | |
| 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) Cancel LIM System Cancel LIM System | ependent(s). Name of Covered Member #1 Retir | | | | |
| 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) Cancel LIM System Cancel LIM | Name of Covered Member #1 Retir | System medical cove | erage for the | e listed retire | ee or widow(er) an |
| Spouse, Sponsored Adult Dependent or Child Signature of Covered Member #1* (REQUIRED) Today's Date (REQUIRED) | | | Dat | e of Birth | Cancel UM System Medical Coverage* |
| Dependent or Child Signature of Covered Member #1* (REQUIRED) Today's Date (REQUIRED) Cancel LIM System | | lationship to Retiree | | | |
| Signature of Covered Member #1* (REQUIRED) Today's Date (REQUIRED) Cancel LIM Syste | Signature of Covered Member #1* (REQUIRED) | · | | | |
| Name of Coursed Marshau #2 Cancel UM Syste | | e ☐ Widow(er) ouse, Sponsored Adult | | s Date (REOI | JIRED) |
| Name of Coursed Marshau #3 Cancel UM Syste | | e ☐ Widow(er) ouse, Sponsored Adult | Today | 3 Date (ILL | |
| Name of Covered Member #2 Relationship to Retiree Date of Birth Medical Coverage | Name of Covered Member #2 | e ☐ Widow(er) ouse, Sponsored Adult | Today' | 3 Date (NEW) | |
| ☐ Retiree ☐ Widow(er) ☐ | □ Retir | e ☐ Widow(er) ouse, Sponsored Adult | | e of Birth | |
| ☐ Spouse, Sponsored Adult | | www. Widow(er) ouse, Sponsored Adult dependent or Child | | | Medical Coverage* |
| Dependent or Child | Signature of Covered Member #2* (REQUIRED) | widow(er) ouse, Sponsored Adult dependent or Child dationship to Retiree widow(er) ouse, Sponsored Adult | | | Cancel UM System Medical Coverage* |
| Dependent or Child | Signature of Covered Member #2* (REQUIRED) | widow(er) ouse, Sponsored Adult dependent or Child dationship to Retiree widow(er) ouse, Sponsored Adult | | | Medical Coverage |

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

| iree/Widow(er) Last Name | Retiree/Widow(| er) First Nam | e M | 11 | Retire | ee ID (not SSN |) |
|---|-----------------------------------|---------------|--------------------|------------|----------|----------------|------------------|
| Section II: | | | | | | | |
| Ancillary Insurance Plans | | | | | | | |
| /ISION PLAN – Vision plan coverage changes may make your election change) | only occur du | ring Retire | e Ann | ual Enro | ollmer | nt. (check or | nly one box |
| Elect vision coverage* | | | Only | Self + S | | Self + Childre | |
| | | L | | Self | | Self + Snous | e Self + Child |
| OR – Reduce vision coverage to the following | | | | |] | | |
| OR – <u>Cancel</u> vision coverage for all members | | | | | | | |
| Provide the following information for dependent(s) to be nose that will fit on this form, list them on a separate she | | he Vision P | an. If | you have | additi | onal depende | ents beyond |
| Dependent Name | ot. | F | Relation | nship | | Date | of Birth |
| | | | | | | | |
| | | | | | | | |
| elow to reduce current Dental Base or Buy Up Plan be enrolled in the same dental plan option. Dental Base Plan | n coverage or | to change | Denta | al plans. | All de | ental plan m | <u>embers mu</u> |
| <u>Elect</u> Dental Base Plan Coverage* - Must have current | enrollment in | | Only | | | Self + Childre | |
| Dental Buy Up Plan in order to elect. | | | | |] | | |
| Provide the following information for <u>dependent(s)</u> to be Dependent Name | covered under to | | ase Pl Relatior | | | Date | of Birth |
| Boportaent Hamo | | | tolation | Юпір | | Bato | OI BILLI |
| | | | | | | | |
| Reduce current enrollment in Dental Base Plan to the I understand if coverage is reduced it cannot be reinst | | date. | Se | elf Only | Sel | f + Spouse | Self + Childre |
| Name(s) of dependent(s) to cancel from dental base p I understand if coverage is cancelled, dependent(s 1) | olan: s) will be ineligi 2) | ble to re-er | roll ir | n either d | dental | plan at a fut | ure date. |
| OR – <u>Cancel</u> coverage <u>for retiree and any covered de</u> <i>I understand if coverage is cancelled, retiree and/o dental plan at a future date.</i> | | | | e to re-ei | nroll ii | n either | |
| Dental Buy Up Plan | | | | | | | |
| Elect Dental Buy Up Plan Coverage* - Must have current | nt enrollment in | Self | Only | Self + S | pouse | Self + Childre | n Self + Fami |
| Dental Base Plan in order to elect. | | | | |] | | |
| Provide the following information for dependent(s) to be Dependent Name | covered under t | | uy Up Relatior | | | Date | of Birth |
| | | | | | | | |
| Reduce current enrollment in Dental Buy Up Plan to the | he following: | | Se | elf Only | Sel | f + Spouse | Self + Childre |
| I understand if coverage is reduced it cannot be reinst | | date. | | | | | |
| Name(s) of dependent(s) to cancel from dental buy up I understand if coverage is cancelled, dependent(s | coverage: s) will be ineligi | ble to re-er | roll ir | n either d | dental | plan at a fut | ure date. |
| 1) | 2) | | | | | | |
| | | | | | | | |

| МІ | Retiree ID (not SSI | N) | | | |
|---|--------------------------------|---|--|--|--|
| | | | | | |
| | Basic Life A (100% premiu | | | | |
| | | | | | |
| | | | | | |
| of the year | r in which you turn a | age 70. | | | |
| make you | ur election change | e) | | | |
|),000 ige 75-79) | \$25,000 (max if age 70-74) | \$50,000 (max under age 70 | | | |
| ☐ Family | ☐ Self ☐ Family | ☐ Self | | | |
| | | | | | |
| ic year iii | which you turn age | 00. | | | |
| ange) 2X | | lat 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. | | | | | |
| e your ele 0,000 | sction change) | \$20,000 | | | |
| | | 1 | | | |
| | L | I | | | |
| | | | | | |
| 0,000 | \$30,000 | \$40,000 | | | |
| | | | | | |
| | 0,000 | ,000 \$30,000 | | | |

^{*}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

| 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

| etiree Last Name | | Re | etiree First Name | | MI | Retiree ID (not SS | N) |
|---|---|------------------------------------|-------------------|----------------|---------------|-----------------------|-----------------------|
| esidential Street Address | s (not P.O. Box) | Cit | ty | State | Zip | Phone Number | Effective Date Change |
| on this form, list the Resources using o • Email: hrs • Fax: (573) | ne following beneficiary em on a separate shee ne of the following met ervicecenter@umsyste 882-9603 Carrie Francke Dr, Su | et. Return com thods: em.edu | pleted form to | the Unive | | | |
| Basic Life Insurar | nce Plan Beneficiary(| ies) | | | | | |
| 1) Name | Date of birth | Relationship | Social S | ecurity number | er | | Share (%) |
| Address | | | | Phone N | umber | | |
| 2) Name | Date of birth | Relationship | Social S | ecurity number | er | | Share (%) |
| Address | | | | Phone N | umber | | |
| Contingent | | | | | | | |
| 1) Name | Date of birth | Relationship | Social S | ecurity numbe | urity number | | Share (%) |
| Address | 1 | | I | Phone N | umber | | |
| 2) Name | Date of birth | Relationship | Social S | ecurity number | urity number | | Share (%) |
| Address | | | L | Phone N | umber | | |
| Accidental Death Primary 1) Name Address | & Dismemberment In | Relationship | | ecurity number | er | eficiary(ies) same a | Share (%) |
| 2) Name | Date of birth | Relationship | Social S | ecurity number | er | | Share (%) |
| Address | | | | Phone N | Phone Number | | |
| Contingent | | | | | | | |
| 1) Name | Date of birth | Relationship | Social S | ecurity number | curity number | | Share (%) |
| Address | | | I | Phone N | umber | | |
| 2) Name | Date of birth | Relationship | Social S | ecurity number | er | | Share (%) |
| Address | | I | I | Phone N | umber | | |
| Primary | surance Plan Benefic | | lo : 10 | | | neficiary(ies) same a | |
| 1) Name | Date of birth | Relationship | Social S | ecurity number | | | Share (%) |
| Address | | | | Phone N | | | |
| 2) Name | Date of birth | Relationship | Social So | ecurity numbe | er | | Share (%) |
| Address | • | • | • | Phone N | umbor | | |

University of Missouri – Retiree Beneficiary Designation Information

| etiree Last Name | | Retiree | Retiree First Name MI Retiree ID (no | | Retiree ID (not S | t SSN) | |
|---|--|-----------------------|--------------------------------------|----------------|-----------------------|-------------------|--|
| Additional Life I | nsurance Plan Benefic | iary(ies) - Contin | ued | | | | |
| 1) Name | Date of birth | Relationship | Social Security nu | mber | | Share (%) | |
| Address | I | I | Phon | e Number | | | |
| 2) Name | Date of birth | Relationship | Social Security nu | mber | | Share (%) | |
| Address | | | Phon | e Number | | | |
| Election/Authori I hereby designate to previous beneficiary | the above beneficiary(ies) | to receive applicable | benefits under the | e plans identi | fied. I hereby revok | e any and all | |
| all purposes and sh | agree that this document n all have the same force an electronically scanned and Adobe Pro. | d effect as an origin | al signature. "Elec | tronic signat | ure" shall include fa | xed versions of a | |
| | | | | | | | |

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.