2022 Annual Enrollment Retiree Benefits Change Form

RESET FORM

Enrollment Period: October 25 – November 5, 2021

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, 2022**

INSTRUCTIONS

- During the Annual Enrollment period, use this form to:
  - **Section I –** Change or cancel medical insurance plans.
  - **Section II –** Add or drop vision or to reduce or drop coverage in all ancillary insurance plans.
  - **Section III –** Signature is required for all changes.
- **Please complete *only* the sections of this form in which changes are requested.**
- Dependents/Members are defined as covered retiree/widow(er), spouse/sponsored adult dependent or eligible dependent children.
- Return completed form **no later than *November 5, 2021,*** 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 Drive, Suite 108, Columbia, MO 65211

ALL REQUESTED CHANGES WILL BE EFFECTIVE JANUARY 1, 2022

SECTION I: MEDICAL INSURANCE

Medicare-eligible Member Options

Step 1: Provide the following information to change the Medicare Advantage Plan choice for a Medicare-eligible retiree or widow(er), and/or any Medicare-eligible dependent(s).

Medicare-eligible Member Name #1				Date of Birth
Relationship to Retiree ☐ Retiree ☐ Widow(er) ☐ Spouse, Sponsored Adult Dependent or Child				
Mailing Address (if different than above Residential Street Address)	City	State	Zip	Phone Number
Signature of Medicare-Eligible Member #1 (REQUIRED)			**Today's Date (REQUIRED)**	

Medicare-eligible Member Name #2				Date of Birth
Relationship to Retiree ☐ Retiree ☐ Widow(er) ☐ Spouse, Sponsored Adult Dependent or Child				
Mailing Address (if different than above Residential Street Address)	City	State	Zip	Phone Number
Signature of Medicare-Eligible Member #2 (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. **All Medicare-eligible members must be enrolled in the same plan.**

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

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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 non-Medicare-eligible retiree or widow(er), and/or any non-Medicare-eligible dependent(s).

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. **All non-Medicare eligible members must be enrolled in the same plan.**

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

Name of Covered Member #2	Date of Birth	Cancel UM System Medical Coverage* ☐
Relationship to Retiree ☐ 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.

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

SECTION II: ANCILLARY INSURANCE PLANS

Vision Plan Changes to vision coverage 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.

Dependent Name	Relationship	Date of Birth

Dental Plan ***(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.*	**Self Only** ☐	**Self + Spouse** ☐	**Self + Children** ☐
Name(s) of dependent(s) to cancel from dental coverage: **Name #1** _____ **Name #2** _____			
OR – **Cancel** coverage for retiree and any covered dependents *I understand if coverage is cancelled it cannot be reinstated at a future date.*			☐

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 and 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.*			☐

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

Dependent Life Insurance Plans* *(check only one box per plan to make your election changes)*

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.* ☐				

*Retiree acknowledges that dependent(s) remains 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 umurl.us/life.

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.*** ☐				

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)**

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 umurl.us/SBC. Paper copies are also available, free of charge, by calling the HR Service Center at 573-882-2146.

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	

University of Missouri – Retiree Beneficiary Designation Information

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

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	

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)**