University of Missouri – Retiree Benefits Change Form

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

INSTRUCTIONS

- **Complete only the sections of this form in which changes are requested. Effective date of change needs to be the first of the month.**
- Dependents/Members are defined as covered retiree/widow(er), spouse/sponsored adult dependent or eligible dependent children.
- Return completed form, prior to the requested effective date, to:
  University of Missouri System, Office of Human Resources
  - Email: hrservicecenter@umsystem.edu
  - Fax: (573) 882-9603
  - Mail: 1105 Carrie Francke Dr., Suite 108, Columbia, MO 65211

MEDICAL INSURANCE*

Changes to medical plan enrollment, other than cancellation for yourself and/or a dependent, may only occur during Retiree Annual Enrollment.

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

Cancel coverage for retiree and/or dependents 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 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)**		**Today's Date (REQUIRED)**	
Name of Covered Member #2	Retiree or Dependent?	Date of Birth	Cancel UM System Medical Coverage** ☐
Signature of Covered Member #2 (REQUIRED)**		**Today's Date (REQUIRED)**	
Name of Covered Member #3	Retiree or Dependent?	Date of Birth	Cancel UM System Medical Coverage** ☐
Signature of Covered Member #3 (REQUIRED)**		**Today's 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.

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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 (If there are any additional dependents to list beyond those that will fit on this form, list all information on a separate sheet): ***I understand if coverage is cancelled it cannot be reinstated at a future date.*** 1)_____ 2)_____			
OR – Cancel coverage for retiree and any covered dependents ***I understand if coverage is cancelled it cannot be reinstated at a future date.***			☐

VISION PLAN – RETIREES ARE NOT ELIGIBLE TO CHANGE AT THIS TIME

Changes to vision coverage may only occur during Retiree Annual Enrollment and is effective January 1 of the following year. Please contact us after October 1st to make any changes to the Vision Plan.

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.***			☐

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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.***			☐	

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.***			☐	

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

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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:
University of Missouri System, Office of Human Resources

- 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	

Required Signature on Page 2

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)**