**2020 Retiree Dependent Medicare Supplement Enrollment Form**

*If you wish to remain enrolled with no changes, you do not need to do anything.*

*However, if you wish to make changes, this completed form must be returned to Benefits Administration by November 27, 2019.*

|  |  |
| --- | --- |
| **Retiree Name:** | **University ID:** |
| **Current UA Retiree Dependent Plan:** Medicare Supplement Plan | |

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| --- | --- | --- | --- | --- | --- | --- |
| **Please complete the information below to elect coverage for 2019.** | | | | | | |
| **Election Type** | | | **Monthly University Contribution (81%)** | | **Monthly Member Premium (19%)** | |
| \_\_ Spouse Only | | | $317 | | $74 | |
| \_\_ Spouse + Child(ren) Age 0 – 25 years  old | | | $923 | | $216 | |
| \_\_ I decline medical and prescription coverage offered by The University of Akron effective January 1, 2020. I understand that I and my eligible dependents may re-enroll for coverage as a result of a family status change or during the next open enrollment period. | | | | | | |
|  | **Name** | **Relationship** | | **Birth Date** | | **Social Security Number** |
| \_\_Enroll  \_\_Terminate |  |  | |  | |  |
| \_\_Enroll  \_\_Terminate |  |  | |  | |  |
| \_\_Enroll  \_\_Terminate |  |  | |  | |  |

By signing this form, I attest that only eligible individuals are covered on this plan. I understand that I may be required to provide evidence of eligibility within 31 days at the request of The University of Akron. I understand this election is effective January 1 through December 31, 2020. Changes to this election may only be made as a result of a family status change. ***I understand that my coverage will be terminated and I will not be eligible for reinstatement if the monthly premiums are not paid within the allotted grace period on my bill.***

**Signature of Retiree or Dependent Date**

**Please mail or fax this completed form by November 27, 2019 to:**

The University of Akron

Office of Benefits Administration

Akron, OH 44325-0602

Fax: 330-972-2336