APPLICATION FOR CONTINUATION IN THE RETIRED/DISABLED STATE GROUP HEALTH OR DENTAL INSURANCE PROGRAM

FOR DAS-HRE USE ONLY
Start Direct Bill Eff._____
Health Code_____
Dental Code_____

1. Name and Home (billing) Address:

_____

_____

_____

_____

2. Social Security No. _____

Reason for Continuation:

☐ Retirement ☐ Sick Leave Insurance Program
State Share: $_____
Retiree Share: $_____
TOTAL: $_____

☐ Long Term Disability (LTD)

☐ Resigning General Assembly Member

3. Date of Birth _____ Payroll No _____

4. Date of Retirement _____ OR;

5. Date approved for Long Term Disability (LTD) _____

6. Month Employee Was Last Added to the Active Employee Monthly Billing _____

7. Enclosed Check is for the Month of _____

8. Present Health Coverage _____ ☐ Single ☐ Family
(Insurance Carrier and Plan)

Present Dental Coverage ☐ Single ☐ Family

9. Have you applied for IPERS or L.T.D. benefits? ☐ Yes ☐ No

I understand and accept that it is necessary and required, in order for health insurance claims to be paid properly, that when I, or my spouse/dependents, if covered under my health plan, become eligible for Medicare, the Medicare eligible person must enroll in both Parts A and B of Medicare. When I am no longer an active employee, Medicare is the primary carrier for Medicare eligible persons.

This note serves as notice that the prescription drug coverage with the State's health plans is considered creditable coverage and I will not be penalized for later enrollment in a Medicare prescription drug plan as long as I am continuously covered by the State's plan. However, I understand that an optional Part D Medicare Prescription Drug Plan may be available to me for coordination of drug benefits with some of the Wellmark Plans. I can contact Wellmark at 1-800-622-0043 for more details. It is my responsibility to notify the insurance carrier of Medicare eligibility.

Please sign and retain a copy of this form for your records.

_____ _____
Signature Date

NOTE:

- The first month's premium, if applicable, must accompany this application. Make the check(s) payable to the insurance carrier.
- You will receive a bill, if applicable, from your insurance carrier for the next premium payment.
- You may sign up for automatic account withdrawal from your checking or saving account. Contact the insurance carrier for details.
- You must complete new applications.
- Individuals 55 years of age and older must be eligible for and must have made application for retirement benefits.
- Individuals 65 years of age and older who are applying for continuation in the health insurance program must have applied for Medicare and completed the insurance application for change to "Medicare Carve-Out" coverage. A copy of the Medicare card or a letter from the Social Security Administration showing Medicare A & B effective dates MUST accompany this paperwork.

Return this form, a check for the first month's premium, if applicable, and the top copy of the insurance application(s), to your department Personnel Assistant.

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