Post 65 2017 Retiree Dependent 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.

Retiree Name:	**University ID:**
Current UA Retiree Dependent Plan: Post 65 Indemnity Plan	

Please complete the information below to elect coverage for 2017.		
Election Type	**Monthly University Contribution (84%)**	**Monthly Member Premium (16%)**
☐ Spouse Only	$322	$61
☐ Spouse + Child(ren) Age 0 – 25 years old	$993	$189
☐ I decline medical and prescription coverage offered by The University of Akron effective January 1, 2017. 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 30 days at the request of The University of Akron. I understand this election is effective January 1 through December 31, 2017. 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 won't be eligible for reinstatement if the monthly premiums are not paid within the allotted grace period.***

Signature of Retiree or Dependent **Date**

Please mail or fax this completed form by November 30, 2016 to:
Benefits Administration, The University of Akron
Administrative Services Building
Akron, OH 44325-0602
Fax: 330-972-2336