

**2020 Retiree Dependent PPO Enrollment Form**

***I****f you wish to remain enrolled with no changes, you do not need to return this form. However, if you wish to make changes, this completed form must be returned to Benefits Administration by November 27, 2019.* **The Working Spouse form must also be returned to Benefits Administration by November 27, 2019 whether you are making changes or not.**

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| **Retiree Name:** | **University ID:** |
| **Current UA Retiree Dependent Plan:**  PPO Plan | |

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| **Please complete the information below to elect coverage for 2020.** | | | | | | |
| **Election Type** | | | **Monthly University Contribution (81%)** | | **Monthly Member Premium (19%)** | |
| \_\_ Spouse | | | **$673** | | **$158** | |
| \_\_ Child(ren) Ages 0 – 25 years old | | | **$606** | | **$142** | |
| \_\_ Spouse and Child(ren) Ages 0 – 25 years old | | | **$1,279** | | **$300** | |
| \_\_ 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 |  |  | |  | |  |
| \_\_ 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, 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 and the Working Spouse Form, if applicable, by November 27, 2019 to:**

Benefits Administration, The University of Akron

Administrative Services Building

Akron, OH 44325-0602

Fax: 330-972-2336