RETIREE MEDICAL PLAN POSTPONEMENT FORM

To **POSTPONE** enrollment into The University of Chicago's Retiree Medical Plan, which provides both medical and prescription drug coverage, because you are enrolled in other health insurance plan, complete, sign and submit this "Form" to the HR Benefits Office via fax to (773)834-0996 or scan and email to benefits@uchicago.edu within 31 days of your termination date or retirement date (whichever occurs first).

Eligibility

You and your eligible dependents may **postpone** enrollment into the Plan if you were either employed by the University:

- Prior to January 1, 2005 in a continuous benefits-eligible position (from hire to termination or retirement date, whichever occurs first) and are at least age 55 on the date of termination or retirement (whichever occurs first), or
- On or after January 1, 2005, are at least age 55 and have completed at least 10 years of continuous benefits-eligible service on the date of termination or retirement (whichever occurs first).

Retiree Information (Please Print)

Retiree Name:

SSN: XXX-XX- Hire Date: Termination or Retirement Date:

Home Address:

City: State: Zip Code:

Home or Cell Phone: Email Address:

Dependent Information (Please Print)

☐ Spouse ☐ Civil Union Partner ☐ Child ☐ Domestic Partner (Registered with the University on or before December 31, 2016)

Name:

SSN: XXX-XX- Date of Birth: Sex: ☐ Male ☐ Female

Dependent Information (Please Print)

☐ Spouse ☐ Civil Union Partner ☐ Child ☐ Domestic Partner (Registered with the University on or before December 31, 2016)

Name:

SSN: XXX-XX- Date of Birth: Sex: ☐ Male ☐ Female

Signature

*I hereby apply to **postpone** medical and prescription drug coverage under The University of Chicago Retiree Medical Plan. This authorization shall remain valid from the date signed below through the effective date of enrollment into the Retiree Medical Plan. A copy of this authorization shall be as valid as the original.*

I must submit a completed Retiree Medical Plan Enrollment Form within 31 days of losing my current health insurance to enroll in the University of Chicago Retiree Medical Plan.

Retiree Signature: Date:

Benefit Representative Signature: Date: