RETIREMENT PACKET

Thank you for your dedication!

You must go on the Employee Portal (online) to enter your intent to retire

You must turn in all (3) forms for processing of your retirement (do not fax):

- ☐ Retirement Notification form (signed by supervisor)
- ☐ Application for Service or Early Retirement Benefits application
- ☐ Application for Retiree Health Insurance Enrollment/Change Form
  - Pre-65 OR Post-65 (complete only ONE side)
  - **You must keep your insurance payments current while waiting to receive your 1st TCRS check (to prevent cancellation)**

Please also provide the following with your retirement paperwork:

- ☐ Copy of your driver's license or photo ID
- ☐ Copy of beneficiary driver's license or photo ID (if survivor option)
- ☐ Copy of Medicare card (if applicable) for retiree and dependent(s)
- ☐ Voided check (if checking account) or savings information

Please carefully review the following information (if applicable) in your Retirement Packet:

- ☐ Qualifications for retirement and insurance at retirement
- ☐ Retiree Health Information
- ☐ MetLife Beneficiary form (only if you have basic life insurance)
- ☐ Medicare - Social Security Verification form (to be completed by Benefits)

You must meet one of the retirement qualifications to be eligible to retire:

- Full retirement – 60 years old with 5 years of service (vested) OR 30 years of service
- Early retirement – 55 years old with 5 years of service (vested) OR 25 – 29 years
- Disability retirement – 5 years of service (vested) OR approved accident on the job
  - To continue health insurance, you must meet the eligibility and be on an approved Leave of Absence (LOA) – while your application is pending w/TCRS

Office of Benefits & Compensation - Retirement
160 S. Hollywood St., Room 108, Memphis, TN 38112
PHONE: (901)416-5344 - FAX: (901)416-6463

For Additional TCRS Information: www.treasury.tn.gov/tcrs

Angela Thomas (Last Names - A - K) 416-5305 - Email: thomasa6@scsk12.org
Janice Avery (Last Names - L - Z) 416-0239 Email: averyjm@scsk12.org
Monica Mays – 416-0546 Email: maysm@scsk12.org

If you have not received a letter confirming processing from TCRS within 30 days of submitting your retirement application, it is strongly recommended that you follow-up on your status by calling TCRS at 1-800-922-7772

RETIREMENT & INSURANCE QUALIFICATIONS

TCRS RETIREMENT QUALIFICATIONS:

- Full retirement –60 years old with 5 years of service (vested) OR 30 years of service
- Early retirement – 55 years old with 5 years of service (vested) OR 25 – 29 years of service
- Disability retirement – 5 years of service (vested) or approved accident on the job
  (must meet the insurance eligibility and be on approved LOA while disability retirement is pending with TCRS to maintain health coverage at approval)

****

CURRENT INSURANCE REQUIREMENT FOR BOTH SCS AND MCS EMPLOYEES AS OF 7/1/2013:

- **Health insurance - If hired after 7/1/2013: Required to complete (15) years of continuous service with the District and participate in a health plan offered by the District for the two (2) years immediately prior to retirement.**

- **Life Insurance - If "retired" after 9/1/2013: Life insurance is 50% of your active coverage at the time of retirement (not to exceed $50,000). Free of charge if you meet the requirements to continue life insurance at retirement**

****

RETIREE INSURANCE QUALIFICATIONS FOR LEGACY SCS EMPLOYEES:

- Health Insurance - If hired prior to 7/1/2013: Required to complete (15) years of continuous service with the District and participate in a health plan offered by the District prior to retirement.
  - Teachers: Can complete a combination of (10) years of service with another school district (as reflected in TCRS or the Tenn Dept of Educ records) **and** complete five (5) years of continuous service with Shelby County Schools immediately prior to retirement.
- Life Insurance - If "retired" after 9/1/2013: Life insurance is 50% of your active coverage at the time of retirement (not to exceed $50,000)

RETIREE INSURANCE QUALIFICATIONS FOR LEGACY MCS EMPLOYEES:

- Health Insurance - If hired prior to 1/1/2007: Required to be covered continuously by a health plan offered by either MCS or SCS or some combination thereof for the five (5) years immediately prior to retirement.
- Health Insurance - If hired after 1/1/2007: Required to be covered continuously by a health plan offered by either MCS or SCS or some combination thereof for the ten (10) years immediately prior to retirement.
- Life Insurance - If "retired" after 9/1/2013: Life insurance is 50% of your active coverage at the time of retirement (not to exceed $50,000)

2015 - 2016 Retiree Health Information

Eligible employees must complete an enrollment form (Pre-65 **or** Post-65) to continue benefits with Shelby County Schools (if eligible). *You must be enrolled in the SCS Retiree Medical Insurance if you would like to participate in the dental and/or the vision plan. However, you can have the medical coverage without dental and/or vision.*

NOTE: Should you cancel medical, dental and/or vision benefits for yourself and/or a dependent, you will NOT be allowed to reinstate coverage (even if you lose coverage elsewhere). You cannot add dental/vision coverage, if you did not have it prior to retirement
NOTE: There is no qualified event period to add your spouse/dependent(s) to retiree coverage (even if they lose coverage elsewhere). To continue dependent coverage at retirement, the dependent(s) must be enrolled in your active health plan prior to retirement.

Pre-65 Retirees - 3 Medical Plans Offered

	Retiree ONLY	Retiree + 1	Family
OAP In-Network Plus	$207.87	$463.24	$646.22
OAP Basic Option	$149.98	$366.62	$511.44
Choice Fund HRA Option	$92.00	$252.34	$352.02

Please note: Prior to your 65th birthday, you must enroll and provide a copy of your Medicare A&B card to Benefits to continue your coverage with Shelby County Schools.

DENTAL & VISION FOR PRE-65 & POST-65 RETIREES

DENTAL COVERAGE – Your premium for dental will be deducted from your TCRS retirement check. You must be enrolled in the SCS Retiree Medical Insurance in order to participate in the dental and vision coverage. Listed below are the costs for dental.

SCS DPPO ($1500) Option	RETIREE ONLY	Retiree + 1	Family
SCS Basic Dental	$25.79 (per month)	$54.17	$77.38

VISION COVERAGE – Your premium for vision will be deducted from your TCRS retirement check. You must be enrolled in the SCS Retiree Medical Insurance in order to participate in the dental and vision coverage. Listed below are the costs for vision.

SCS VISON	RETIREE ONLY	Retiree + 1	Family
SCS Vision Plan	$6.16 (per month)	$11.79	$19.13

LIFE INSURANCE PREMIUM: Free of charge, if you meet requirements to continue at retirement

Pre-65 Retiree Medical Benefits – Cigna

Pre-65 Retiree Medical Benefit	OAP IN-NETWORK Plus	OAP Basic Option		CHOICE FUND HRA Option	
	Network Only Plan	Network	Out-of-Network	Network	Out-of-Network
Annual Deductible					
Retiree	$150	$500	$1,000	$1,500	$3,000
Retiree + 1	$300	$750	$1,500	$2,250	$4,500
Family	$450	$1,000	$2,000	$3,000	$6,000
Annual Health Fund provided to retirees and dependents	N/A	N/A		$500 / retiree, $750 / retiree + 1, $1,000 / family	
Out-of-Pocket Maximum					
Coinsurance	100%	80%	50%	80%	50%
Retiree	$2,500	$4,000	$12,000	$4,500	$13,500
Retiree + 1	$5,000	$8,000	$24,000	$9,000	$27,000
Family	$7,500	$12,000	$36,000	$12,700	$38,100
Lifetime Plan Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Office Visit					
Primary Care Physician	$20 copay	$25 copay	50%*	80%*	50%*
Specialist	$35 copay	$35 copay	50%*	80%*	50%*
Hospital					
Inpatient	$500 copay*	80%*	50%*	80%*	50%*
Outpatient	$250 copay*	80%*	50%*	80%*	50%*
Emergency Room	$150 copay*	$150 copay*	$150 copay*	80%*	80%*
Urgent Care	$75 copay*	$75 copay*	$75 copay*	80%*	80%*
TeleHealth / MD Live	$20 copay	$25 copay	N/A	$38 copay; 20%	N/A
X-Ray, Labs, Etc.	100%*	80%*	50%*	80%*	50%*
Preventive Care (mammograms, PAP tests, physicals, immunizations)	100%	100%	Not covered	100%	Not covered
Behavioral Health/Substance Abuse	$500 copay*	80%*	50%*	80%*	50%*
Inpatient	$35 copay	$35 copay	50%*	80%*	50%*
Outpatient					
Prescription drugs					
Deductible	None	None	$100 per person	None	$100 per person
Retail (30-day supply)			50%*		
Generic	$10 copay	$10 copay		$10 copay	50%*
			50%*		
Preferred Brand	80% *($20 min/$50 max)*	80% *($20 min/$50 max)*		80% *($20 min/$50 max)*	50%*
			50%*	70% *($45 min/$75 max)*	
Non-Preferred Brand	70% *($45 min/$75 max)*	70% *($45 min/$75 max)*			50%*
Mail Order (90-day supply)	3 x Retail	3 x Retail	Not covered	3 x Retail	Not covered

*after deductible

Summaries of Benefits and Coverage ("SBCs"), as required by the Affordable Care Act, are available on the Employee Benefits webpage. Hard copies of the SBCs are also available at the Employee Benefits Department.

Health Reimbursement Account (HRA) – Pre-65 Retirees only

If you enroll in the Choice Fund HRA medical plan option it will include a health reimbursement account (HRA), funded by Shelby County Schools, to help you pay for some of the costs of eligible health care expenses.

At the start of the plan year, Shelby County Schools will deposit a specific dollar amount in the HRA. The medical summary on the previous page shows the Shelby County Schools' 2015 - 2016 contribution amounts for the HRA. Cigna manages the claims process for you and applies your HRA funds to pay 100% of your eligible health care expenses until the money is used up. Here's how it works:

- When you go to most in-network providers, the provider does not collect any money from you at the point of service. Instead, the provider sends the claim directly to Cigna.
- Cigna processes the claim and identifies the amount due to the provider, including any discounts.
- Claims are deducted from your HRA account up to the balance of your account. Once the HRA fund balance has been exhausted, then ongoing claims are paid by the retiree as part of the deductible. When those two parts have been exhausted then the plan acts like a traditional plan where the employer pays 80% and the retiree picks up the remaining 20%, up to the out of pocket maximum.
- If you leave the plan or Shelby County Schools, you lose your HRA account funds.
- You may roll over funds from one year to the next.

Cigna will send out quarterly statements to those retirees who participate in the Choice Fund HRA plan.

Pre-65 Retiree Dental Benefits - Cigna

Benefit	DPPO ($1,500) Plan	
	Network	Out-of-Network
Annual Deductible		
Individual	$50	$100
Family	$150	$300
Annual Plan Maximum	$1,500	$1,500
Diagnostic and Preventive	100%	100%
Basic Services		
Basic	80%*	80%*
Periodontic Treatment	50%*	50%*
Re-lining/Re-basing of Existing Removable Dentures	50%*	50%*
Repair or Re-cementing of Crowns, Inlays, Onlays, Dentures or Bridgework	50%*	50%*
Major Services		
Major	50%*	50%*
Crowns, Jackets and Cast Restoration Benefits	50%*	50%*
Prosthodontic Benefits	50%*	50%*
TMJ and Implants	Not covered	Not covered
Orthodontia Services	50%	50%
Deductible	None	None
Dependent Children	Up to age 26	Up to age 26
Adults	Not covered	Not covered
Lifetime Maximum for Orthodontia	$1,500	$1,500

Pre-65 Retiree Vision Benefits - Cigna

Benefit	Davis Vision	
	Network	Out-of-Network
Benefit Frequency		
Exam / Lenses / Contacts	12 months	12 months
Frames	24 months	24 months
Exam	$10 copay	Up to $30 allowance
Lenses		
Single Vision	$20 copay	Up to $25 allowance
Bifocal	$20 copay	Up to $35 allowance
Trifocal	$20 copay	Up to $45 allowance
Lenticular	$20 copay	Up to $60 allowance
Lens Options		
UV Coating	$12 copay	Not Covered
Tint / Scratch Resistance	Included	Not Covered
Basic Polycarbonate	Up to $30 copay	Not Covered
Anti-Reflective		
Standard	Included	Not Covered
Premium	$13 copay	Not Covered
Ultra	$25 copay	Not Covered
Progressive	Included	Not Covered
Standard	$40 copay	Not Covered
Premium		
Frames	100% - Davis Collection Frames $130 credit / allowance + 20% discount – All Others	Up to $30 allowance
Contact Lenses		
Medically Necessary	$10 exam copy, then 100%	Up to $225 allowance
Elective		Up to $75 allowance

Benefit	Davis Vision	
	Network	Out-of-Network
	Davis Collection $10 exam copay + $20 copay + 4 boxes/multi-pack - Disposable, or $20 copay + 2 boxes/multi-packs - Planned Replacement ***Non-Collection*** $10 exam copay, $150 credit/allowance + 15% discount - (materials only); 15% discount - (Evaluation, Fitting & Follow-up)	
Other Services Corrective Vision Services	Up to 25% discount or 5% of advertised special	Not Covered

SHELBY COUNTY SCHOOLS

Retiree Health Care Plan
Enrollment/Change Form

(Please complete this form in its entirety)

Administered by
Connecticut General Life Insurance Company
Cigna HealthCare of Tennessee, Inc.

Cigna.

A

☐ OPEN ENROLL. ☐ CHANGE
☐ NEW ENROLL. ☐ REINSTATE

EFFECTIVE DATE OF ADD/CHANGE/ CANCELLATION (MM/DD/CCYY)	SCS PLAN GROUP	CIGNA ACCOUNT NO.	BRANCH CODE
	PRE-65 RETIREE	3211484	

EMPLOYER NAME	EMPLOYER ADDRESS
SHELBY COUNTY SCHOOLS	160 S. HOLLYWOOD, MEMPHIS, TN 38112

TYPE OF CHANGE:

☐ **Add Dependent(s) *** Date: _____
☐ **Cancel Dependent(s) *** Last Date of Coverage: _____
☐ **Cancel Coverage *** Last Date of Coverage: _____
*** List Names in Section B**

☐ **Survivor**
☐ **Other** _____
☐ **Change to Single** ☐ **Change to Family**
☐ **Change to Retiree + One Dependent**

PRE-65 RETIREE

MEDICAL COVERAGE TIER

☐ RETIREE ONLY ☐ RETIREE + ONE ☐ RETIREE + FAMILY
☐ OAP IN-NETWORK PLUS ☐ OAP BASIC ☐ CHOICE FUND HRA

DENTAL COVERAGE TIER (MUST HAVE MEDICAL COVERAGE)

☐ RETIREE ONLY ☐ RETIREE + ONE ☐ RETIREE + FAMILY
☐ DPPO 1500 ☐ WAIVE DENTAL

☐ **DAVIS VISION** ☐ WAIVE VISION
☐ RETIREE ONLY ☐ RETIREE + ONE ☐ RETIREE + FAMILY

B — RETIREE

RETIREE NAME *(Last)* *(First)* *(M.I.)* SOCIAL SECURITY NO.

DATE OF BIRTH (MM/DD/CCYY) GENDER ☐M ☐F HOME PHONE ( ) WORK PHONE ( ) E-MAIL ADDRESS

ADDRESS *(Street)* *(City)* *(State)* *(Zip Code)*

DEPENDENT INFORMATION — Last Name / First Name / M.I.	Relationship	DEPENDENT SOCIAL SECURITY NO.	DATE OF BIRTH MM DD CCYY	GENDER	DEPENDENT COVERAGES	SCS EMPLOYEE? Yes No	(check one)
Spouse				☐M ☐F	☐ Medical ☐ Dental ☐ Vision	☐ ☐	☐ Add ☐ Cancel
Dependent *	Relationship			☐M ☐F	☐ Medical ☐ Dental ☐ Vision	☐ ☐	☐ Add ☐ Cancel
Dependent *	Relationship			☐M ☐F	☐ Medical ☐ Dental ☐ Vision	☐ ☐	☐ Add ☐ Cancel
Dependent *	Relationship			☐M ☐F	☐ Medical ☐ Dental ☐ Vision	☐ ☐	☐ Add ☐ Cancel

*** DEPENDENTS -** Up to age 26. Adult children married or unmarried and living or not living with parent qualify for this coverage. If totally disabled prior to age 26, attach proof of disability for eligibility review.

C

OTHER HEALTH CARE COVERAGE:
Do you or your dependents have other health insurance under a group plan, HMO, or Medicare? ☐ Yes ☐ No *If yes, please provide the following:*

NAME OF PERSON COVERED	SOCIAL SECURITY NO.	EFFECTIVE DATE	MEDICARE Part A	MEDICARE Part B	HIC# (MEDICARE ID NUMBER)	MEDICAID	OTHER INSURANCE CARRIER
			☐	☐		☐	☐
			☐	☐		☐	☐

D

SIGNATURE - I have read this form and certify that all statements contained are true and correct to the best of my knowledge. I understand any material misrepresentation will result in the cancellation of my coverage and the denial of claims plus reimbursement to the health plan of any benefit payments. I understand that if my coverage contains limitations on pre-existing conditions that these limitations will be stated in the plan. I accept the provisions on the reverse side of this form which I have read and understand.

RETIREE'S SIGNATURE DATE

FOR OFFICE USE ONLY	DED CODE	CLASSIFICATION	INPUT BY	OTHER

DISTRIBUTION: Original - Shelby County Schools **Employee** - Please make a copy for your records

(OVER)

PROVISIONS

- "CIGNA HealthCare" refers to various operating subsidiaries of CIGNA Corporation. Products and services are provided by these subsidiaries and not by CIGNA Corporation. These subsidiaries include Connecticut General Life Insurance Company, Tel-Drug, Inc. and its affiliates, CIGNA Behavioral Health, Inc., Intracorp, and HMO or service company subsidiaries of CIGNA Health Corporation and CIGNA Dental Health, Inc.
- I agree, for myself and my dependents, that, in the event any health services provided are the primary responsibility of any other party by way of other group health coverage or by the act or omission of another person to fully inform the healthplan and will execute such assignments, liens or other documents which maybe necessary to enable the healthplan to recover the value of the services provided. I further agree that in the event I or any of my dependents collect benefits or damages from any other party who has primary responsibility for services provided by the healthplan, I will immediately reimburse the healthplan to the extent of services provided, to the extent permitted by state law.

FRAUD WARNING

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

AUTHORIZATION TO DEDUCT CONTRIBUTIONS

I authorize deductions from my earnings of the required contributions, if any, toward the cost of the coverage. This authorization applies only if employee contributions are required.

SPECIAL PROVISION FOR EMPLOYERS WITH SECTION 125 PLANS

By allowing an individual to enroll in the Insurance Plan other than during the open enrollment period, CIGNA HealthCare or Connecticut General Life Insurance Company does not waive any terms of its contract. Further, by allowing an individual to enroll in the Insurance Plan other than during an open enrollment period, CIGNA HealthCare or Connecticut General Life Insurance Company does not thereby express any opinion regarding the appropriateness of the change under Section 125 of the Internal Revenue Code or the terms of the employer's Section 125 Plan.

Post-65 Retirees

Cigna Medicare Surround & Drug Plan

If you are Medicare eligible at retirement, you must be enrolled in Medicare A&B to continue your coverage with the Shelby County School's medical program. Medicare becomes primary and you can chose between the two supplement plans offered by SCS (if applicable). This SCS plan will be considered secondary or your supplemental plan.

What is Cigna-Medicare Surround & Cigna HealthSpring Rx (PDP)?

Cigna Medicare Surround is an indemnity medical plan that helps pay some of the health care costs that Medicare does not cover, such as your Medicare Part A and B deductibles and coinsurance. With the Cigna Medicare Surround plan you have the freedom to choose any health care provider that accepts Medicare. Cigna Health Spring Rx (PDP) is a national Medicare Part D drug plan offered by Cigna HealthCare.

What is Cigna-HealthSpring Preferred with Rx plan (HMO)?

This is a Medicare Advantage Health Maintenance Organization (HMO) with Part D prescription drug coverage. You must provide a primary care physician with this plan and you must be in one of the approved service areas to participate in this plan.

Please read the following carefully:

- Please provide our office a copy of you & your dependent(s) Medicare A&B card(s) when received.
- Failure to sign up for Medicare A&B could cause a delay in your SCS coverage or may even cause termination of your benefits with SCS.
- You can only be in one supplement and prescription drug plan at a time. If you attempt to have multiple supplemental/prescription plans, your coverage with SCS will terminate.
- If you have not signed up for Medicare, please request SCS Benefits to complete the enclosed Social Security Verification form. This form may be needed by the Social Security Administration to begin your Medicare A&B benefits.
- Health rates are subject to change each year
- Other SPLIT rates may apply if you have dependents that do not have Medicare A&B

LIFE INSURANCE PREMIUM: **Free of charge, if you meet requirements to continue at retirement**

MEDICARE SURROUND RATES

2015-16 Post-65 Retirees (1/1/2016 - 12/31/2016)

Classified	Monthly Premium
Retiree with Medicare	$ 106.80
Retiree+1 with Medicare	$ 213.61
Family with Medicare	$ 320.41
Certified - Less than 15 years of service	
Retiree with Medicare	$ 106.80
Retiree+1 with Medicare	$ 213.61
Family with Medicare	$ 320.41
Certified - 15-19 years of service ($25.00 credit) w/Medicare A&B	
Retiree with Medicare	$ 81.80
Retiree+1 with Medicare	$ 188.61
Family with Medicare	$ 295.41
Certified - 20-29 years of service ($37.50 credit) w/Medicare A&B	
Retiree with Medicare	$ 69.30
Retiree+1 with Medicare	$ 176.11
Family with Medicare	$ 282.91
Certified - 30 or more years of service ($50 credit) w/Medicare A&B	
Retiree with Medicare	$ 56.80
Retiree+1 with Medicare	$ 163.61
Family with Medicare	$ 270.41

MEDICARE ADVANTAGE RATES

Classified	Monthly Premium
Retiree with Medicare	$ 71.41
Retiree+1 with Medicare	$ 142.82
Family with Medicare	$ 214.24
Certified - Less than 15 years of service	
Retiree with Medicare	$ 71.41
Retiree+1 with Medicare	$ 142.82
Family with Medicare	$ 214.24
15-19 years of service ($25.00 credit) w/Medicare A&B	
Retiree with Medicare	$ 46.41
Retiree+1 with Medicare	$ 117.82
Family with Medicare	$ 189.24
Certified - 20-29 years of service ($37.50 credit) w/Medicare A&B	
Retiree with Medicare	$ 33.91
Retiree+1 with Medicare	$ 105.32
Family with Medicare	$ 176.74
Certified - 30 or more years of service ($50 credit) w/Medicare A&B	
Retiree with Medicare	$ 21.41
Retiree+1 with Medicare	$ 92.82
Family with Medicare	$ 164.24

SHELBY COUNTY SCHOOLS

Retiree Health Care Plan
Enrollment/Change Form

(Please complete this form in its entirety)

Administered by
Connecticut General Life Insurance Company
Cigna HealthCare of Tennessee, Inc.

Cigna.

A

☐ OPEN ENROLL. ☐ CHANGE
☐ NEW ENROLL. ☐ REINSTATE

EFFECTIVE DATE OF ADD/CHANGE/CANCELLATION (MM/DD/CCYY)

SCS PLAN GROUP: **POST-65 RETIREE**

CIGNA ACCOUNT NO.: **3211484**

BRANCH CODE

EMPLOYER NAME: **SHELBY COUNTY SCHOOLS**

EMPLOYER ADDRESS: **160 S. HOLLYWOOD, MEMPHIS, TN 38112**

TYPE OF CHANGE:

☐ Add Dependent(s) * Date: _____
☐ Cancel Dependent(s) * Last Date of Coverage: _____
☐ Cancel Coverage * Last Date of Coverage: _____
* List Names in Section B

☐ Survivor
☐ Other _____
☐ Change to Single ☐ Change to Family
☐ Change to Retiree + One Dependent

POST-65 RETIREE

MEDICAL COVERAGE TIER
☐ RETIREE ONLY ☐ RETIREE + ONE ☐ RETIREE + FAMILY
☐ MEDICARE SURROUND & PART D PHARMACY PLAN

DENTAL COVERAGE TIER (MUST HAVE MEDICAL COVERAGE)
☐ RETIREE ONLY ☐ RETIREE + ONE ☐ RETIREE + FAMILY
☐ DPPO 1500 ☐ WAIVE DENTAL

B — RETIREE

RETIREE NAME (Last) (First) (M.I.) SOCIAL SECURITY NO.

DATE OF BIRTH (MM/DD/CCYY) GENDER ☐M ☐F HOME PHONE ( ) WORK PHONE ( ) E-MAIL ADDRESS

ADDRESS (Street) (City) (State) (Zip Code)

DEPENDENT INFORMATION Last Name / First Name / M.I.	DEPENDENT SOCIAL SECURITY NO.	DATE OF BIRTH MM DD CCYY	GENDER	DEPENDENT COVERAGES	SCS EMPLOYEE? Yes No	(check one)
Spouse			☐M ☐F	☐ Medical ☐ Dental	☐ ☐	☐ Add ☐ Cancel
Dependent * Relationship			☐M ☐F	☐ Medical ☐ Dental	☐ ☐	☐ Add ☐ Cancel
Dependent * Relationship			☐M ☐F	☐ Medical ☐ Dental	☐ ☐	☐ Add ☐ Cancel
Dependent * Relationship			☐M ☐F	☐ Medical ☐ Dental	☐ ☐	☐ Add ☐ Cancel

* **DEPENDENTS -** Up to age 26. Adult children married or unmarried and living or not living with parent qualify for this coverage. If totally disabled prior to age 26, attach proof of disability for eligibility review.

C

OTHER HEALTH CARE COVERAGE:
Do you or your dependents have other health insurance under a group plan, HMO, or Medicare? ☐ Yes ☐ No *If yes, please provide the following:*

NAME OF PERSON COVERED	SOCIAL SECURITY NO.	EFFECTIVE DATE	MEDICARE Part A	MEDICARE Part B	HIC # (MEDICARE ID NUMBER)	MEDICAID	OTHER INSURANCE CARRIER
			☐	☐		☐	☐
			☐	☐		☐	☐

D

SIGNATURE - I have read this form and certify that all statements contained are true and correct to the best of my knowledge. I understand any material misrepresentation will result in the cancellation of my coverage and the denial of claims plus reimbursement to the health plan of any benefit payments. I understand that if my coverage contains limitations on pre-existing conditions that these limitations will be stated in the plan. I accept the provisions on the reverse side of this form which I have read and understand.

RETIREE'S SIGNATURE DATE

FOR OFFICE USE ONLY	DED CODE	CLASSIFICATION	INPUT BY	OTHER

DISTRIBUTION: Original - Shelby County Schools **Employee** - Please make a copy for your records

(OVER)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0787

REQUEST FOR EMPLOYMENT INFORMATION

WHAT IS THE PURPOSE OF THIS FORM?

In order to apply for Medicare in a Special Enrollment Period, you must have or had group health plan coverage within the last 8 months through your or your spouse's current employment. People with disabilities must have large group health plan coverage based on your, your spouse's or a family member's current employment.

This form is used for proof of group health care coverage based on current employment. This information is needed to process your Medicare enrollment application.

The employer that provides the group health plan coverage completes the information about your health care coverage and dates of employment.

HOW IS THE FORM COMPLETED?

- Complete the first section of the form so that the employer can find and complete the information about your coverage and the employment of the person through which you have that health coverage.
- The employer fills in the information in the second section and signs at the bottom.

WHAT DO I DO WITH THE FORM?

Fill out Section A and take the form to your employer. Ask your employer to fill out Section B. You need to get the completed form from your employer and include it with your Application for Enrollment in Medicare (CMS-40B). Then you send both together to your local Social Security office. Find your local office here: www.ssa.gov.

GET HELP WITH THIS FORM

- **Phone:** Call Social Security at **1-800-772-1213**
- **En español:** Llame a SSA gratis al **1-800-772-1213** y oprima el 2 si desea el servicio en español y espere a que le atienda un agente.
- **In person:** Your local Social Security office. For an office near you check www.ssa.gov.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0787

REQUEST FOR EMPLOYMENT INFORMATION

SECTION A: To be completed by individual signing up for Medicare Part B (Medical Insurance)

1. Employer's Name

2. Date ___ / ___ / ____

3. Employer's Address

City

State

Zip Code

4. Applicant's Name

5. Applicant's Social Security Number ___ – ___ – ____

6. Employee's Name

7. Employee's Social Security Number ___ – ___ – ____

SECTION B: To be completed by Employers

For Employer Group Health Plans ONLY:

1. Is (or was) the applicant covered under an employer group health plan? ☐ Yes ☐ No

2. If yes, give the date the applicant's coverage began. (mm/yyyy)
___ / ____

3. Has the coverage ended? ☐ Yes ☐ No

4. If yes, give the date the coverage ended. (mm/yyyy)
___ / ____

5. When did the employee work for your company?

From: (mm/yyyy) ___ / ____

To: (mm/yyyy) ___ / ____

Still Employed: (mm/yyyy) ___ / ____

6. If you're a large group health plan and the applicant is disabled, please list the timeframe (all months) that your group health plan was primary payer.

From: (mm/yyyy) ___ / ____

To: (mm/yyyy) ___ / ____

For Hours Bank Arrangements ONLY:

1. Is (or was) the applicant covered under an Hours Bank Arrangement? ☐ Yes ☐ No

2. If yes, does the applicant have hours remaining in reserve? ☐ Yes ☐ No

3. Date reserve hours ended or will be used? (mm/yyyy)
___ / ____

All Employers:

Signature of Company Official

Date Signed ___ / ___ / ____

Title of Company Official

Phone Number (___) ___ – ____

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information is 0938-0787. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, MD 21244-1850.

SERVICE OR EARLY RETIREMENT NOTIFICATION

☐ Legacy MCS Employee ☐ Legacy SCS Employee ☐ SCS Employee

You must go on the Employee Portal (online) to enter your intent to retire

Name: _____ SSN: _____-_____-_____

Address: _____ City: _____ State/Zip: _____

Home Phone: _____ Cell Phone: _____ Personal Email: _____

Work Location: _____ Position: _____

Retirement Effective Date (required): _____

Please read the following information carefully, providing your signature below certifies that you have read and clearly understand the following:

- I MUST meet one of the retirement qualifications below to be eligible to retire:
  - Full retirement –60 years old with 5 years of service (vested) OR 30 years of service
  - Early retirement – 55 years old with 5 years of service (vested) OR 25 – 29 years of service
  - Disability retirement – 5 years of service (vested) or approved accident on the job
    (Please note: you must be on an approved LOA to continue health insurance – if you meet the qualifications)
- If this Retirement Notification is submitted but I DO NOT meet the above qualifications, I understand that this form may be processed as a resignation.
- I have contacted Tennessee Consolidated Retirement System at 1-800-770-8277 or 1-615-741-1971 to check my eligibility for retirement.
- I have requested an estimate of my retirement benefits from Tennessee Consolidated Retirement System or I have calculated my benefits by accessing the TCRS Benefits Calculator at www.treasury.tn.gov/tcrs.
- Teachers shall give a written notice of retirement at least thirty (30) days before the effective date of retirement to remain in good standing.
- Once this form is submitted, I understand that I must go through a process to rescind my application and that my information has to be approved by Human Resources. This includes cancelling retirement and/or changing my date of retirement (requests to rescind are not automatically approved).
- In order to have my retirement application processed completely and in a timely manner, I MUST complete and submit this form as well as the Application for Service or Early Retirement Benefits (both forms should be submitted at the same time).

Employee Signature (required):_____ Date: _____

Supervisor Signature: _____ Date: _____

PLEASE SUBMIT RETIREMENT INFORMATION TO:

Shelby County Schools
160 S. Hollywood St., **ROOM 108**
Memphis, TN 38112-4892
Office of Benefits & Retirement, ATTN: Angela Thomas (Last Names A-K) or Janice Avery (Last Names L-Z)

Application for Service or Early Retirement Benefits

Tennessee Consolidated Retirement System
502 Deaderick Street
Nashville, Tennessee 37243-0201
1-800-770-8277 • treasury.tn.gov/tcrs

Do NOT complete this form if you are applying for disability retirement benefits. Refer to pages 5 and 6 for detailed instructions. Do not sign this form until it is notarized *(see Section 6)*.

SECTION 1. MEMBER INFORMATION *(Completed by the Applicant.)*

Member ID | Social Security No. | Date of Birth

Full Name

Mailing Address

City | State | Zip Code

Email | Phone Number

Last Employer *(Department of Institution Name)*

Title of Position | Date Employment Terminated

Date of Retirement ☐ 55th Birthday ☐ 60th Birthday ☐ Day After Last Paid Day ☐ Other _____

SECTION 2. BENEFICIARY INFORMATION *(One beneficiary or estate required regardless of plan selected. If no beneficiary is selected, TCRS will assume a beneficiary election of Estate if you choose a single life annuity plan.)*

As recipient of the benefit plan selected in Section 3, I designate the following beneficiary:

Full Name

Mailing Address

City | State | Zip Code

Beneficiary's Date of Birth | Beneficiary's SSN

Relationship to TCRS Member

Gender ☐ Male ☐ Female

SECTION 3. PAYMENT PLAN ELECTION *(You may choose only one "Single Life Annuity Plan" OR one "Survivor Option" payment plan. Selecting more than one payment plan will result in the application process being delayed.)*

SINGLE LIFE ANNUITY PLANS - In the event of your death, any remaining balance of your accumulated contributions and interest will be paid in a lump sum to the surviving designated beneficiary.

☐ Regular/Maximum Plan - Monthly benefit payable to you for your lifetime with all benefits ceasing at death.

☐ Social Security Leveling - An increased benefit until you reach age 62. Beginning the month after your 62nd birthday, your benefit from the TCRS will be reduced, at which time you will also become eligible for Social Security benefits. This benefit will be payable to you for life with all benefits ceasing at death. This retirement plan requires a benefit estimate from the Social Security Administration that has been done within a year of your date of retirement from TCRS.

OR

SURVIVOR OPTIONS - Your monthly benefit will be reduced from the regular/maximum plan. In the event of your death, your designated beneficiary will receive:

☐ Option I - Monthly benefits equal to yours for your beneficiary's lifetime. Should your beneficiary die before you, your reduced monthly allowance will remain the same.

☐ Option II - Monthly benefits equal to 50% of yours for your beneficiary's lifetime. Should your beneficiary die before you, your reduced allowance will remain the same.

☐ Option III - Monthly benefits equal to yours for your beneficiary's lifetime. Should your beneficiary die before you, your allowance will revert to the amount you would have received under the Regular/Maximum plan.

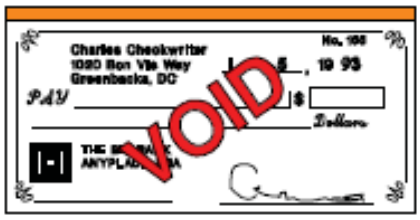
☐ Option IV - Monthly benefits equal to 50% of yours for your beneficiary's lifetime. Should your beneficiary die before you, your allowance will revert to the amount you would have received under the Regular/Maximum plan.

SECTION 4. DIRECT DEPOSIT INFORMATION

Type of Account: ☐ Checking ☐ Savings

Financial Institution

Routing Number Account Number



If you want your benefit directly deposited into a checking account, tape a voided, preprinted check in this box. You may cover the text with the voided check. If you want your benefit deposited into multiple accounts, please complete the Direct Deposit form located at tcrs.tn.gov.

PLEASE NOTE: TCRS no longer issues monthly retirement benefits by check. If TCRS has not received your authorization to direct deposit your benefit payment, a debit card will be issued and mailed to your home address and all future TCRS benefit payments will be made by adding your monthly benefit to the debit card balance.

SECTION 5. WITHHOLDING SELECTION *(Select one.)*

☐ A. I elect NOT to have income tax withheld from my pension. (*Do not complete lines B or C if you choose this selection.)*

☐ B. I want the following TOTAL amount withheld from each payment: $_____

OR

I want the following PERCENTAGE withheld from each payment: _____%

(Do not complete lines A or C if you choose this selection.)

☐ C. I want my withholding from each payment to be figured using the following filing status and exemptions:

Filing Status: ◯ Single ◯ Married ◯ Married, but withholding at a higher single rate

Total Exemptions Claimed: _____

In addition to the calculated deduction based on filing status and exemptions, I want the following additional amount withheld from each pension payment. $_____.

SECTION 6. SIGNATURE AND NOTARY *(This form must be signed and notarized, then forwarded to employer for certification.)*

☐ Under the penalties of perjury, I attest that, as of the date of this application for retirement benefits, I am either a United States citizen or a qualified alien as described by 8 U.S.C. Section 1641(b). I acknowledge and understand that should I knowingly and willfully make a false, fictitious or fraudulent statement or representation relative to my citizenship or immigration status, or conspire to defraud the state by securing a false claim allowed or paid to another person, I shall be liable under either The Tennessee Medicaid False Claims Act pursuant to Tennessee Code Annotated, Sections 71-5-181 through 71-5-185 or The False Claims Act pursuant to Tennessee Code Annotated, Sections 4-18-101 through 4-18-108 and may have a criminal action brought against me alleging a violation of 18 U.S.C. Section 911, which provides that whoever falsely and willfully represents himself to be a citizen of the United States shall be fined under this title or imprisoned not more than three (3) years or both.

I also acknowledge that I have attached documentation proving said citizenship. *(Please see Section 1 instructions on pages 5 and 6 for a complete list of acceptable documentation.)* **Note: Photocopies of the documents are acceptable and any document submitted will not be returned to you.)**

Member's Signature _____ Date _____

State of Tennessee / County of _____

_____, who personally appeared before me on this, the _____ day of

_____, 20_____, makes oath that (he)(she) executed the foregoing instrument.

(Notary Seal) _____ _____

Notary Public *My Commission Expires*

SECTION 7. EMPLOYER CERTIFICATION ***(This section must be completed by official department payroll personnel. If member has been out of service for more than 60 days, complete only Sections F and G below.)***

A. **MEMBER'S TERMINATION DATE** *(last paid date of service, annual leave or sick leave)*: _____

B. Please list all individual payroll periods that the employee was paid on for his/her remaining months of service that have not been reported to TCRS at this time. If any salaries are estimated, indicate by marking "(Est)" and provide any changes or revisions in the actual payroll information as quickly as possible. Any longevity payments or career ladder payments should be itemized along with any payments made for sick leave, annual leave, vacation time, bonus pay, etc. Please attach additional pages if necessary.

Breakdown of Final Salary					
Month	Payroll Period	Type of Payment	Amount	Employee Contributions	Service Credit

C. Please indicate the total salary for the current year and the portion of the year the salary represents. If the current year is a partial year, also include the salary from the previous year.

Current Year Salary: $_____ Number of Months Included: _____

D. The service represented is: ❑ Full-Time ❑ Part-Time (percentage worked) _____ %

E. The member is paid on: ❑ Fiscal Year (July 1 - June 30) ❑ Academic Year (Sept. 1 - Aug. 31)
❑ Calendar Year (Jan. 1 - Dec. 31) ❑ Other: _____

F. If this member worked less than 12 months per year, indicate the total number of days worked this year.

A full year consists of: ❑ 180 Days ❑ 200 Days ❑ 220 Days ❑ Other: _____

G. Please certify the unused sick leave this member had remaining. Do not include days for which member received a lump-sum payment. *(For employees who are Fire and Police, only certify days.)*

Days: _____ Hours: _____ Hours Worked Per Day: _____

How many sick days did the employee accrue annually over the last three (3) years?

This Year: _____ Last Year: _____ Prior Year: _____

Employer's Signature	Date
Employer's Address	
Department	
Email	Phone Number

When to File an Application for Retirement

Your application for retirement should be forwarded to TCRS 60 to 90 days prior to your last paid day of service. The last paid day of service is either your last day of employment or the last day for which you are paid annual and/or sick leave. Your application cannot be filed more than 150 days prior to your last paid day of service. For eligibility requirements and questions regarding the continuation of insurance, please contact Benefits Administration at 800-253-9981.

Directions for Completing

Section 1 - The date employment terminated is the last working day (including all annual and/or sick days) for which you are paid. The effective date of retirement is the day immediately following the last paid day or the first day of eligibility for benefits (i.e., 60th birthday). Payment will be made retroactive to your date of retirement not to exceed 150 days prior to receipt of the application in our office.

If you are a United States citizen and are applying for retirement benefits from TCRS through the submission of this application, you must provide one (1) of the following:

- A valid driver's license or photo identification license issued by the Tennessee Department of Safety or a valid driver's license or photo identification license from another state where the issuance requirements are at least as strict as those in Tennessee, as determined by the Department of Safety;
- An official birth certificate issued by the United States or any of its territories; however, Puerto Rican birth certificates issued before July 1, 2010 shall not be recognized;
- A United States government-issued certified birth certificate;
- A valid, unexpired United States passport;
- A United States certificate of birth abroad (DS-1350 or FS-545);
- A report of birth abroad of a United States citizen (FS-240);
- A certificate of citizenship (N560 or N561);
- A certificate of naturalization (N550, N570 or N578);
- A United States Citizen identification card (I-197, I-179);
- Any successor document to six items listed above;
- A social security number that the Department may verify with the Social Security Administration

If you are a "qualified alien" and are applying for retirement benefits from TCRS through submission of this application, you must provide two (2) forms of documentation of identity and immigration status as determined by the United States Department of Homeland Security to be acceptable for verification through the Systematic Alien Verification for Entitlements ("SAVE") program. (For the definition of a "qualified alien", please refer to 8 U.S.C. Section1641.) Common types of documents used to establish immigration status include, but are not limited to, the following:

- I-327 (Reentry Permit);
- I-551 (Permanent Resident Card or "Green Card");
- I-571 (Refugee Travel Document);
- I-766 (Employment Authorization Card);
- Machine Readable Immigrant Visa (with Temporary I-551 language);
- Temporary I-551 stamp (on passport or I-94);
- Unexpired foreign passport;
- WT (visitor for business)/WB (visitor for pleasure) Admission Stamp in unexpired foreign passport;
- I-20 (Certificate of Eligibility for Nonimmigrant F(1) student status – "student visa");
- DS2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status).

Common types of documents used to establish identity include, but are not limited to, the following:

- Driver's license;
- Identification card with photograph issued by federal, state or local government agencies or entities;
- School identification card with photograph;
- Voter's registration card;
- United States military card or draft record;
- Military dependent's identification card;
- United States Coast Guard Merchant Mariners Document (MMD) Card;
- Native American tribal document;
- Driver's license issued by a Canadian government authority

Please note, photocopies of the above-referenced documents are acceptable. Documents submitted will not be returned to you.

Section 2 - If you select the Regular/Maximum Plan or Social Security Leveling, you may designate an individual or your estate as beneficiary. If you select Option I - IV, you must designate an individual as beneficiary. Proof of the beneficiary's birth date should be included.

Section 3 - You must select **only one** benefit plan. If you choose the Social Security Leveling Plan, a certified estimate from the Social Security Administration of your Social Security benefits payable at age 62 must accompany your retirement application. This estimate should not be dated more than one year prior to filing your retirement application. Forms to obtain the proper type of Social Security estimate must be obtained from the Social Security Administration at 800-772-1213 or your local Social Security office.

Section 4 - Please attach a voided check OR provide your savings account information. As required by state law, TCRS monthly benefits will be deposited directly to the checking or savings account indicated on your retirement application. Payments will be available on the last working day of each month. You will be notified in writing of any changes made to the amount of your net benefit. All correspondence and year-end statements will be mailed to your home address.

Section 5 - TCRS benefits are subject to federal taxation. However, it is your choice whether to have federal income tax withheld from your TCRS pension. Before completing Section 5, please consult your tax preparer regarding the correct filing status and number of exemptions for your monthly pension. If you leave this section blank, we will automatically assign a status of married with three exemptions.

Section 6 - Must be signed before a Notary and notarized to be valid.

Section 7 - Submit your signed application to your employer to complete Section 7. Upon completion, the application should be returned to the Tennessee Consolidated Retirement System. If you have been out of service for more than 60 days, Items A-F in Section 7 do not need to be completed. However, in order for you to be properly credited with your unused sick leave, Item G must be certified by your employer.

Acknowledgement

All applications will be acknowledged by letter after we receive them. If you do not receive an acknowledgment letter within two weeks, please contact Member Services at 800-770-8277.

If you should return to service on a part-time or full-time basis with an agency covered by the retirement system, you should notify TCRS to avoid an overpayment of retirement benefits.

Metropolitan Life Insurance Company

MetLife®

BENEFICIARY DESIGNATION

Please read Instructions on next page before completing this form. Do not erase or attempt to make corrections; use a new form.

Name of Employer _____

Group Policy No. _____ Insured's Social Security No. _____

In accordance with the conditions of the Group Policy listed above, I hereby revoke any previous designations of primary beneficiary(ies) and contingent beneficiary(ies) (if any) and designate as primary beneficiary(ies) and contingent beneficiary(ies) (if any) in the event of the insured's death, the following:

Primary Beneficiary Designation

Full Name (Last, First, Middle Initial)	Relationship	Date of Birth	Address (Street, City, State, Zip)	Share %

Payment will be made in equal shares or all to the survivor unless otherwise indicated. TOTAL: 100%

In the event said primary beneficiary(ies) predecease(s) the insured, I designate as contingent beneficiary(ies)

Contingent Beneficiary Designation

Full Name (Last, First, Middle Initial)	Relationship	Date of Birth	Address (Street, City, State, Zip)	Share %

Payment will be made in equal shares or all to the survivor unless otherwise indicated. TOTAL: 100%

If no beneficiary or contingent beneficiary designated shall be living following the insured's death, the amount payable by reason of the insured's death shall be payable as provided in the Group Policy.

Note: See Next Page for Important Information Trust(ee) Designation (applies only if a trust has been created in an executed trust agreement)

Name of Trustee(s) _____

Address _____ City _____ State _____ Zip Code _____

and successor(s) in trust, as Trustee(s) under _____
(Title of Agreement)

Dated _____ executed by me and said Trustee(s).

MetLife shall not be responsible for the application or disposition of the proceeds by said Trustee(s), and the receipt of the proceeds by said Trustee(s) shall be full discharge of the liability of MetLife under the Group Policy.

If this form is executed by the insured, it is understood and agreed, however, that if MetLife receives proof satisfactory to it that the aforesaid trust has been revoked or is not in effect at the insured's death, the beneficiary shall be the insured's Estate, and payment to the estate's legal representative based on such proof shall be full discharge of liability of MetLife under the Group Policy or certificate.

If this form is executed by the current owner (who is not the insured), it is understood and agreed, however, that if MetLife receives proof satisfactory to it that the aforesaid trust has been revoked or is not in effect at the insured's death, the beneficiary shall be the current owner, if living at the insured's death, or the current owner's estate if the current owner is not living at the insured's death, and payment to the estate's legal representative based on such proof shall be full discharge of liability of MetLife under the Group Policy or certificate.

Trust(ee) (Under Will) Designation (applies only if a trust has been set forth in your Will) The trust(ee) under any last Will and Testament of mine as shall be admitted to probate.

If for any reason whatsoever, no Trust(ee) under any such last Will and Testament shall be duly appointed, I hereby designate **My Estate** as beneficiary and any payment made in good faith to the legal representative of my estate shall be full discharge of the liability of MetLife under the Group Policy.

I reserve the right to change the designated beneficiary(ies) at any time without (his/her/their) consent.

(Please Print)

Name of Insured or Owner (if assigned) _____ Daytime Phone No. _____

Street Address _____ City _____ State _____ Zip Code _____

Signature of Insured or Owner (if assigned) _____ Date Signed _____

Submit Completed Form To Employer and Retain a Copy for Your Records

GENERAL BENEFICIARY INFORMATION

You may find the following definitions helpful in completing your Beneficiary Designation form.

Primary Beneficiary: Your primary beneficiary should be the individual(s) or organization that you wish to receive the insurance proceeds. You may have the proceeds divided among several primary beneficiaries. To do this, you must indicate what percentage of the proceeds you would like them to receive. Your total shares must equal 100%.

Contingent Beneficiary: Your contingent beneficiary should be the individual(s) or organization that you wish to receive the insurance proceeds if your primary beneficiary(ies) (see definition above) predecease(s) the insured. You may have the proceeds divided among several contingent beneficiaries. To do this, you must indicate what percentage of the proceeds you would like them to receive. Your total shares must equal 100%.

Trust(ee) Designation: If you plan to have the insurance proceeds distributed through a Trust, you should complete this section with the appropriate information. Your Trust(ee) will be held fully responsible for the application for and disposition of the insurance proceeds.
This section should only be used if you have a legally drawn inter vivos trust agreement or an appropriate Trust(ee) is designated under your Last Will and Testament. If you complete this section, do NOT complete the Primary or Contingent Beneficiary sections.

An inter vivos trust is a trust established during the life of the trustor (the person who creates the trust) for the benefit of the trustor or other living persons.

INSTRUCTIONS FOR COMPLETING BENEFICIARY DESIGNATION

1. Fill in the insured's Name of Employer, Group Policy Number (found on your Certificate) and Social Security Number at the top of the form. At the bottom of the form, fill in the name of the insured person or owner (if assigned), the daytime phone number, address, and sign and date the form.

2. Fill in the Primary Beneficiary(ies) and Contingent Beneficiary(ies), if any. For each Primary and Contingent Beneficiary listed, enter the relationship (when the relationship of the beneficiary is other than by blood or marriage, the relationship should be shown as "Nonrelative"), date of birth, address(es) (permanent residence) and percentage of share (all shares must add up to 100%).

3. If you wish to name a Trust(ee) as beneficiary, complete one of the two Trust(ee) Designations **instead** of the Primary and Contingent Beneficiary sections. If the trust is an inter vivos trust, check only the first Trust(ee) Designation box, and complete the top Trust(ee) designation. You should enter (1) the name and address of the Trust(ee); (2) the Title of the Agreement; and (3) the date of its execution. **NOTE: AN INTER VIVOS TRUST MUST BE A LEGALLY DRAWN AGREEMENT.**

If you wish to make a Trust(ee) under Will Designation, check only the second Trust(ee) Designation box. **NOTE: A TRUST(EE) UNDER WILL (OR TESTAMENTARY TRUST(EE) MUST BE ESTABLISHED UNDER THE LEGALLY DRAWN LAST WILL AND TESTAMENT OF THE INSURED OR OWNER (IF ASSIGNED).**

4. The owner of the coverage should sign and date the form in the spaces provided. Retain a copy for yourrecords.

5. Give the completed form to the Employer.

If you wish to name more beneficiaries than this form provides for, secure an additional copy. Complete your list of beneficiaries on that form. Attach the additional form to the first, indicating clearly on each form the number of additional forms attached. For example, if three forms are used, number the forms as follows: 1 of 3, 2 of 3 and 3 of3.

It is important that you review your beneficiary designation periodically to ensure that the beneficiary information

you supplied is up to date. You may change or revoke your beneficiary designation at any time by completing a

new Beneficiary Designation form.