



Application to Continue Benefits--Retiree
South Dakota State Employee Benefit Program
500 East Capitol Avenue Pierre, SD 57501-5070
Phone: 1.877.573.7347, option 2
Fax: 605-773-6840
<http://benefits.sd.gov>

Name: _____ SSN or Insurance ID: _____
 Last First MI

Mailing Address: _____
 Street City State Zip Code

Date of Birth: ____/____/____ Phone: _____ Email: _____

1) Health Election

- I elect to continue health coverage through the **Retiree** Health Plan.
- I elect to continue health coverage through the **COBRA** Health Plan for 18 months then enroll in the Retiree Health Plan.
- I **DO NOT** elect to continue health coverage for myself or my eligible dependent(s).

2) Please check the Health Plan desired. You must check ONE of the following:

- Latitude Health Plan (\$500 Deductible)
- \$1000 Deductible Plan
- \$1800 Deductible Plan

3) Coverage

- Retiree Only Spouse Only Retiree, Spouse, and/or child(ren)
- Retiree & 1 child Retiree & 2 children Retiree & 3 + children

4) Participant and/or dependent information for each person who will be continuing coverage:

Name	Birth Date	Social Security Number

5) Non-tobacco User or Tobacco User?

- I am **not** a tobacco user My covered spouse is **not** a tobacco user
- I am a tobacco user My covered spouse is a tobacco user

6) Method of Payment

If you choose the Direct Payment Plan, the premiums for ALL products can be deducted from your bank account. However, the South Dakota Retirement System can withhold only Health Plan premiums.

- South Dakota Retirement System (Health Only)
- Direct Payment Plan (Fully complete the enclosed form and attach a voided check.)
- Deduct from my spouse's monthly SDRS benefits
 (My spouse's SSN# _____.) Spouse's signature: _____
 (over)

GROUP TERM LIFE BENEFIT ELECTION

Term Life coverage ends the last day of the month of your 70th birthday. There is no conversion policy.

If you currently have life coverage, you may continue the current amount in force or decrease the amount in increments of \$1,000. The minimum amount that may be continued is \$25,000.

6) Please check the appropriate level of life coverage desired. You must check ONE of the following:

- I **DO NOT** elect to continue my group term life coverage
- I **DO** elect to continue the total amount in-force
- I **DO** elect to continue the Basic amount of \$25,000
- Other**, specify \$_____, 000
- N/A**, Spouse/Dependent Coverage

7) Accidental Death & Dismemberment (AD&D) Coverage. You must check ONE of the following:

AD&D provides a life benefit in the case of accidental death and dismemberment. AD&D must equal the life coverage.

- Yes, I want AD&D
- No, I do not want AD&D
- Does Not Apply

8) You must complete the Designation of Beneficiary(ies) below each time you complete this form if you continue life coverage.

If you do not designate beneficiary(ies) for your life benefit, the proceeds will be paid to your estate. If you designate beneficiary(ies), your primary beneficiary(ies) will receive the life benefit plan proceeds. Contingent beneficiary(ies) will receive the benefit proceeds if the primary beneficiary(ies) are deceased. If you have special instructions regarding beneficiary(ies) or would like to designate more than the space provides, attach an additional page and indicate "Attachment" on this form. **For your protection, scratch outs and whiteouts are not accepted.**

DESIGNATION OF PRIMARY BENEFICIARY(IES)

Name	Address	Relationship	Share to Each
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

DESIGNATION OF CONTINGENT BENEFICIARY(IES)

Name	Address	Relationship	Share to Each
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I authorize the South Dakota Retirement System (SDRS) to release to the South Dakota Bureau of Human Resources my address, phone number, and/or email on file for the purpose of the Bureau of Human Resources contacting me regarding my health insurance, life insurance, and/or flexible benefits.

I represent that the foregoing information is, to the best of my knowledge and belief, accurate. I agree that to retain coverage, I (we) must abide by the Plan's provisions.

Applicant Signature

Date Signed