

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

Mailing Address: _____
 Street City State Zip Code

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

1) Health Election

- I **DO** elect to continue health coverage for myself or my eligible dependent(s)
- 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:

- \$750 Deductible Plan
- \$1800 Deductible Plan

3) Coverage

- Retiree Only
- Spouse Only (Retiree only rate)
- Retiree & Child(ren)
- Retiree & Spouse
- Family

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

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, 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