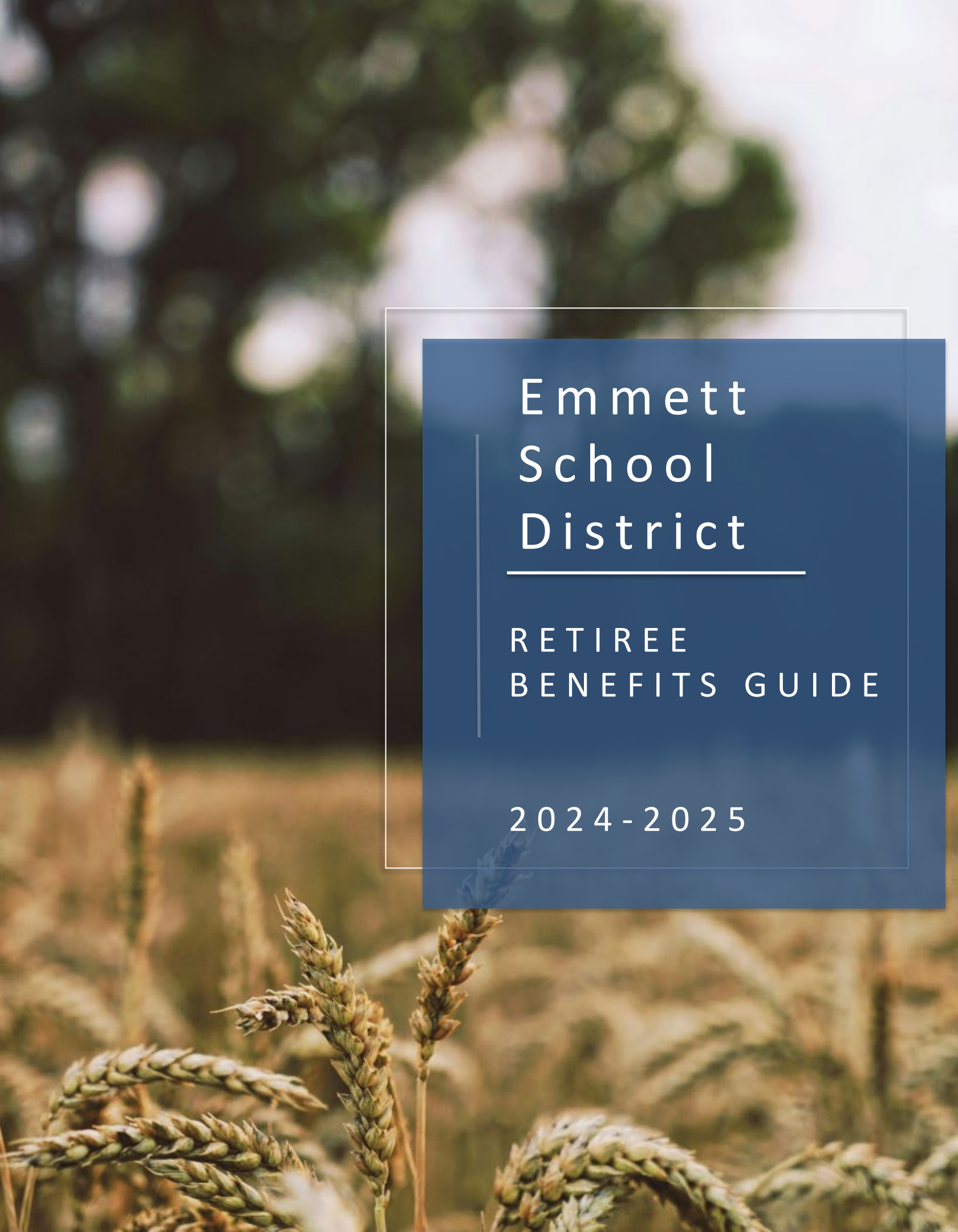

Emmett School District

RETIREE BENEFITS GUIDE

2024-2025

Retiree Benefit Guide 2024-2025

This guide contains information regarding the Medical, Dental, Vision and Life benefits offered to you as an under Age 65 Retiree of the Emmett School District. If you have any questions about the information provided, please contact our benefit consulting team at Acrisure for assistance at (208) 765-2620.

Not Making Changes:

- If you do not need to make changes to your current plans, you will not need to complete any of the forms in this packet. All your plans will remain the same with new monthly rates beginning on September 1, 2024.

Making Changes:

- To change plans or add/remove dependents, you must complete the corresponding Medical, Dental, Vision or Life forms included in this packet. Please be sure to include your signature and indicate the changes on the top of the form.

  * You are only able to make changes to medical, dental, vision and life benefits if you elected them at your initial retirement.

- If you have your premiums deducted from your un-used sick leave or PERSI retirement, please understand that any changes you make to your enrollment are subject to PERSI review and eligibility. You may be required to pay for your premiums by direct bill if you do not have funds available.

- Contact PERSI if you need to view your account balance.

- **If you or your spouse are turning 65 this year, please contact Acrisure at (208) 765-2620 for more information about the Retiree Benefits for Medicare-eligible Retirees.**

All forms must be completed and returned to Human Resources by August 16, 2024.
You can mail, fax, or email the forms to Brandy Marquez.

By Mail: Brandy Marquez
119 N Wardell Avenue
Emmett, ID 83617

By Fax: (208) 365-2961
Attention: Brandy

By Email: bmarquez@isd221.net

PLEASE NOTE:

› Independent School District of Emmett will be staying with Regence this year. The District was able to lower the PPO Deductible from $750 to $500, the IRS Guidelines required the H.S.A to increase the deductible to $3200

Insurance Premiums

Medical – Regence $500 Deductible PPO Plan

	Retiree Premium
Employee Only	$816.10
Employee & Spouse	$1,548.30
Employee & 1 Child	$1,116.30
Employee & 2+ Children	$1,291.80
Family	$1,778.30

Medical – Regence $3,200 Deductible HSA Plan

	Retiree Premium
Employee Only	$690.20
Employee & Spouse	$1,280.70
Employee & 1 Child	$923.80
Employee & 2+ Children	$1,069.10
Family	$1,471.20

Delta Dental

	Retiree Premium
Employee Only	$35.60
Employee & Spouse	$79.00
Employee & 1 Child	$68.45
Employee & 2+ Children	$101.85
Family	$136.30

Willamette Dental *Dental Blue Connect*

	Retiree Premium
Employee Only	$50.12
Employee & Spouse	$108.49
Employee & 1 Child	$96.36
Employee & 2+ Children	$143.47
Family	$192.14

Vision

	Retiree Premium
Employee Only	$7.83
Employee & Spouse	$15.69
Employee & Child(ren)	$16.78
Family	$26.81

2024 – 2025 Medical Plans

Plan Highlights:	Option 1: Regence $500 PPO	Option 2: Regence $3,200 HSA
Deductible (Calendar Year) Individual Family	 $500 $1,000	 $3,200 $5,500
Coinsurance (In-Network) *Cost-sharing after deductible is met*	Plan pays 70% / You pay 30%	Plan pays 80% / You pay 20%
Out-of-Pocket Maximum *(Once member reaches this, plan will pay 100% for remainder of calendar year)* Individual Family	*(Includes Deductible + Coinsurance + Copays)* $5,00 $10,000	*(Includes Deductible + Coinsurance)* $5,500 $11,000
Physician Office Visit	**No Deductible** **Primary Care:** $30 copay **Specialist:** $45 copay	 **Primary Care:** $15 (after deductible) **Specialist:** $40 (after deductible)
Preventive Care	Covered 100%	Covered 100%
Diagnostic Labs / Imaging	No deductible up to $400, then applied to deductible + coinsurance	Applied to deductible + coinsurance
Hospitalization/Maternity	Applied to deductible + coinsurance	Applied to deductible + coinsurance
Emergency Room	30% after $300 copay per visit (waive if admitted)	$300 Copay + Applied to deductible + coinsurance
Pharmacy / RX Preferred Generic: Preferred Brand Name: Non-Preferred Brand Name: Specialty:	 $10 (deductible waived) 25% 50% N/A	**Deductible & OOP combined w/Medical** $10 (deductible waived) $30 (after ded) $60 (after ded) $150 (after ded)

Regence PPO vs. Regence HSA

Regence PPO

- ✓ Members pay flat copays for physician office visits and most prescriptions.
- ✓ Great choice for members who have ongoing medical costs and prefer copays and upfront coverage for services.

Regence HSA

- ✓ The Regence HSA is a high-deductible health plan. Members receive coverage for medical services once they reach their deductible.
- ✓ Great choice for members with minimal medical expenses each year who want to save money on health insurance premiums.

- ➢ Both plans include 100% coverage for Preventive Care Services with no copay and no deductible.

Delta Dental

PROVIDER NETWORK	PPO	PREMIER
Annual Deductible (Individual / Family)	None	None
	Plan Pays:	Plan Pays:
Preventive Care *(Exam, cleanings, x-rays)*	70-100%	70-100%
Basic Procedures *(Fillings, extractions, root canal)*	70-100%	70-100%
Major Procedures *(Crowns, bridges, dentures)*	50%	50%
Annual Maximum Benefit *(Per Member)*	**$1,000**	**$1,000**

Visit www.deltadentalid.com to view network providers, claims, and member discounts

Willamette Dental (Dental Blue Connect)

BENEFITS	COPAY
General Office Visit	$15 Copay
Annual Benefit Maximum	No Annual Maximum
****Must go to the Willamette Dental Clinic for services****	
Preventive (Cleanings, X-Rays, Exam)	Covered 100% after Copay
Fillings	$15 Copay
Extraction / Surgical Extraction	$15 Copay / $75 Copay
Root Canal	$50 Copay
Crowns & Bridges	$150 Copay (each service)
Dentures	$200 Copay
Orthodontia	$1,500 Copay
Nitrous Oxide	$20 Copay
Dental Implant	N/A

Vision

LifeMap Choice Vision Insurance

In Partnership with VSP®

PROVIDER NETWORK	VSP Provider
Annual Eye Exam	$0 copay
Lenses *(every 12 months)*	$25 materials copay
Single vision, lined bifocal, lined trifocal lenses; polycarbonate lenses for children	Covered in Full
Frames *(every 12 months)*	$150 Allowance
Contact Lenses *(instead of frames)* *(every 12 months)*	$150 Allowance

Other VSP Benefits:	• Retinal Screening: Guaranteed price as an enhancement to your WellVision Exam • Laser Vision Correction: 15% discount at contracted facilities

You do not need a card to access your VSP benefits. Simply give your Eye Clinic your Name and DOB. Dependents covered on vision will be accessed under the Employee's Information.

FIND VSP PROVIDERS AT: WWW.VSP.COM

Retiree Life Insurance

Employer Paid Life Insurance	
Options	**Retiree Monthly Premium**
$30,000	**$82.50**
$20,000	**$55.00**
$10,000	**$27.50**
$5,000	**$13.75**

* Only available to Retirees who opted-in prior to retirement

Benefit Contact Information

Benefit Plan	Carrier Name	Website	Phone Number
Benefit Advocates	Acrisure	acrisure.com/northwest	877.765.2620
Medical	Regence	regence.com	888.494.2583
Dental	Willamette Dental	willamettedental.com	855.433.6825
Dental	Delta Dental of Idaho	deltadentalid.com	800.356.7586
Vision	VSP Vision Plan	vsp.com	800.877.7195
Life /LTD	LifeMap	Lifemapco.com	1.800.794.5390

DELTA DENTAL

deltadentalid.com

Group Insurance Benefits Request
Idaho School Retirees

Retirees Name _____ Subscriber Number _____

Birth Date _____

Address _____ Phone Number _____

City/State/Zip _____ Date of Retirement _____

Coverage paid by School District through _____, 20_____

Signed, School District Official _____

School District's Name and Number_____

School District's Address _____

Total monthly dental premium: $_____ Total back premiums/adjustments: $_____

Sufficient sick leave available to cover 1st payment due? Yes ☐ No ☐

Sufficient sick leave available to cover back premiums/adjustments? Yes ☐ No ☐

Are you over the age of 65? Yes ☐ No ☐

Please pay the Delta Dental premium of $_____until my sick leave entitlement is exhausted. I understand that rates, benefits and continuing eligibility for coverage for me and my dependents are all subject to the Master Contract between the School District and Delta Dental of Idaho. I understand the School District will notify me of any rate changes. I realize that should the Contract between the School District from which I retired and Delta Dental of Idaho be terminated, my coverage through Delta Dental of Idaho will terminate.

Please include the following eligible dependents for coverage under Delta Dental.

Dependent Spouse's Name_____Birthdate_____

Dependent Child's Name and Birthdate:

Name_____Birthdate_____

Name_____Birthdate_____

Name_____Birthdate_____

I understand that if coverage is voluntarily terminated for myself, it can never be reinstated. I may add or terminate my dependents only when a status change has occurred. Dependent additions are subject to the contractual limitations stated in the contract between Delta Dental and the School District.

Signature: _____ Date: _____

Instructions:

Complete this form, including signatures by the School District Official and Retiree, and monthly premium amount. Send to Delta Dental of Idaho, 555 E. Parkcenter Blvd, Boise, ID, 83706 by the tenth of the month preceding retirement. Delta Dental of Idaho will send notification to the Public Employee Retirement System.

Statewide Schools Retiree Application

Requested Effective Date _____

❑ **Retiree Deferral Request**

SCHOOL DISTRICT INSTRUCTIONS: Please have the Retiree complete and sign this form, then complete your portion on the back. Have your participating school district or school related group official sign and return the form to Blue Cross of Idaho.

RETIREE INSTRUCTIONS: Please complete the information below and sign and date the back of the form.

Applicant Information *(Retiree)*

First Name	Last Name	Middle Initial	Marital Status	Gender
			❑ Single ❑ Married ❑ Divorced ❑ Widowed	❑ Male ❑ Female
Address	City, State, Zip Code	Phone Number		
Social Security Number	Blue Cross of Idaho Identification Number	Blue Cross of Idaho Group Number		
Medicare Beneficiary Number	Date of Retirement	Birthdate		

Dependent Information - Please include the following eligible dependents who are currently covered under my program and will continue to be covered under my Retiree Program. List all eligible dependents you wish to enroll, including any child who is under the age of 26; or who is medically certified as disabled and dependent on parent for support *(copy of certification required)*.

Dependent Spouse's Name	Spouse's Social Security Number	Medicare Beneficiary Number	Birthdate
Dependent Child's Name	Child's Social Security Number	Medicare Beneficiary Number	Birthdate
Dependent Child's Name	Child's Social Security Number	Medicare Beneficiary Number	Birthdate

Medical Coverage - Please choose appropriate coverage from the selections below.
Retiree enrollment may be equal to or lesser than active employee enrollment.

UNDER 65

	Health	Dental (if applicable)	Vision (if applicable)
Employee	❑ PPO ❑ HSA ❑ POS	❑ PPO Dental Plan ❑ Dental Blue Connect	☐
Spouse	❑ PPO ❑ HSA ❑ POS	❑ PPO Dental Plan ❑ Dental Blue Connect	☐
Child	❑ PPO ❑ HSA ❑ POS	❑ PPO Dental Plan ❑ Dental Blue Connect	☐
Child	❑ PPO ❑ HSA ❑ POS	❑ PPO Dental Plan ❑ Dental Blue Connect	☐

OVER 65

	Retiree Plan with RX	Retiree Plan without RX	Dental Coverage (if applicable)	Vision (if applicable)	**Medicare Supplement***	**Medicare Advantage****
Employee	☐	☐	❑ PPO Dental Plan ❑ Dental Blue Connect	☐	☐	☐
Spouse	☐	☐	❑ PPO Dental Plan ❑ Dental Blue Connect	☐	☐	☐

*** A Medicare Supplement enrollment form is required to enroll in Blue Cross of Idaho's Medicare Supplement plans. Call 1-888-GO CROSS (1-888-462-7677) toll free to request a form and plan information.**

****A Medicare Advantage enrollment form is required to enroll in Blue Cross of Idaho's Medicare Advantage plans. Call 1-888-492-2583 toll free to request a form and plan information.**

FOR OFFICE USE ONLY

Group Number	Subgroup	Effective Date	Plan ID			Class	Reason Code
			M	D	V		

Street Address: 3000 E. Pine Ave., Meridian, ID 83642-5995 • *Mailing Address:* P.O. Box 7408, Boise, ID 83707-1408 • (208) 345-4550

Form No. 4-150 (11-20)

Current/Prior Coverage
(For Coordination of Benefits, please complete the section below. Use extra paper if necessary).

Name	Name of Carrier	Policy Number	Type of Policy (Group or Individual)	Date of Policy		Will Current Policy Continue?
				Start Date (mm/dd/yy)	End Date (mm/dd/yy)	

Benefits offered to Retirees **under age 65**, under the Blue Cross of Idaho School Insurance Program, are to be the same benefits offered to active employees. If you had dental coverage through BCI while an active employee, you will be allowed to continue that dental coverage as a Retiree, as long as the group offers that benefit to its employees.

Retirees and/or spouses **over the age of 65** will be enrolled in our Blue Cross of Idaho School Insurance Over 65 Medicare Program and **must** be enrolled in Parts A and B. You are eligible for dental benefits if the participating school district or school related group you retired from participates in BCI's school program and you were enrolled in a dental plan through your participating school district or school related group for **12 months prior to enrolling in this retiree program.**

Please note that Blue Cross of Idaho cannot guarantee billing or payment of all policies selected by PERSI. If for any reason your premiums cannot be paid by PERSI, Blue Cross of Idaho will bill you directly.

RETIREE'S signature: _____ Date: _____

I authorize the Public Employee Retirement System of Idaho (PERSI) and Blue Cross of Idaho to exchange my address and enrollment information for the purpose of administering this plan.

RETIREE'S signature: _____ Date: _____

Sign for Deferment Only

I choose to defer my enrollment in the retiree program as well as my draw on unused sick leave entitlement with PERSI. I understand if I choose not to continue coverage at the time of retirement I may not be able to enroll at a later date. Later enrollment is possible only if your school district or school related group remains with Blue Cross of Idaho and you maintain continuous coverage. If your school district chooses another carrier, you will not be able to enroll in the program.

RETIREE'S signature: _____ Date: _____

TO BE COMPLETED BY THE PARTICIPATING SCHOOL DISTRICT OR SCHOOL RELATED GROUP:

Not necessary for currently enrolled retirees

Coverage paid by the Participating School District or School Related Group through the month of: _____, 20_____

_____

Signature of Participating School District or School Related Group Official

_____ _____

Name of Participating School Group or School Related Group *Group Number*

DISCRIMINATION IS AGAINST THE LAW

Blue Cross of Idaho and Blue Cross of Idaho Care Plus, Inc., (collectively referred to as Blue Cross of Idaho) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Blue Cross of Idaho does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Blue Cross of Idaho:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Blue Cross of Idaho Customer Service Department. Call 1-800-627-1188 (TTY: 711), or call the customer service phone number on the back of your card. If you believe that Blue Cross of Idaho has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with Blue Cross of Idaho's Grievances and Appeals Department at:

Manager, Grievances and Appeals
3000 E. Pine Ave., Meridian, ID 83642
Telephone: 1-800-274-4018
Fax: 208-331-7493
Email: ***grievances&appeals@bcidaho.com***
TTY: 711

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Grievances and Appeals team is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at ***https://ocrportal.hhs.gov/ocr/portal/lobby.jsf***, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TTY). Complaint forms are available at ***http://www.hhs.gov/ocr/office/file/index.html***.

ATTENTION: If you speak Arabic, Bantu, Chinese, Farsi, French, German, Japanese, Korean, Nepali, Romanian, Russian, Serbo-Croatian, Spanish, Tagalog, or Vietnamese, language assistance services, free of charge, are available to you. Call 1-800-627-1188 (TTY: 711).

Arabic انتبه: إذا كنت تتحدث اللغة العربية ، فإن خدمات المساعدة اللغوية متاحة لك مجانًا اتصل على 1-800-627-1188 (للصم والبكم: 711).

Bantu: ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-800-627-1188 (TTY: 711).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-627-1188 (TTY：711)。

Farsi توجه: اگر به زبان فارسی صحبت می کنید، خدمات رایگان پشتیبانی زبان، در دسترس شما است. شماره تماس 1-800-627-1188 (TTY:711).

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-627-1188 (ATS : 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-627-1188 (TTY: 711).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-627-1188（TTY:711）まで、お電話にてご連絡ください。

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-627-1188 (TTY: 711)번으로 전화해 주십시오.

Nepali: ध्यान दनुिहोस्: तपाईंले नेपाली बोलनुहुन्छ भने तपाईंको नमिति भाषा सहायता सेवाहरू नःिशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-627-1188 (टटिाइ: 711) ।

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-627-1188 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-627-1188 (телетайп: 711).

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-627-1188 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-627-1188 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-627-1188 (TTY: 711.

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-627-1188 (TTY: 711).

LifeMap Assurance Company®
200 SW Market Street
P.O. Box 1271, M/S E8L
Portland, OR 97207-1271
www.LifeMapCo.com
(800) 794-5390

Independent School District of Emmett #221 – ID03898I

PERSI BILLED RETIREE VISION ENROLLMENT CHANGE FORM

****INSTRUCTIONS****
Please print when completing ALL entries.
Upon completion, please send all pages to **LifeMap Assurance Company (LifeMap) AND your Benefits Administrator**:

LifeMap Assurance Company
Attn: Billing
P.O. Box 1271, MS E8L
Portland OR 97207-1271

AND

Independent School District of Emmett #221
Attn: Benefits Administrator
119 N Wardwell Ave, Emmett, ID 83617

TO BE COMPLETED BY SCHOOL DISTRICT

Employee's Retirement Date:_____ Retiree Effective Date: _____ Class:_____

_____ _____
Signature of School District Benefits Administrator **Date Signed**

General Information (to be fully completed)

Retiree's Name (Last, First, MI)			Date of Birth
Social Security Number		Telephone Number	
Mailing Address: Street / Apt #	City	State	Zip
Email Address			

Retiree Coverage Election / Monthly Premium Rate (Retiree must election option(s) below)

Please note: Coverage must have been in force prior to retirement and be elected within 31 days of retirement date.

☐ Retiree Only / $7.83	☐ Retiree and Spouse / $15.69
☐ Retiree and Child(ren) / $16.78	☐ Retiree and Family / $26.81

LifeMap®

Independent School District of Emmett #221 – ID03898I

PERSI BILLED RETIREE VISION ENROLLMENT CHANGE FORM

(continued)

Dependents to be enrolled: You must have elected dependent vision coverage as an active employee to continue dependent coverage as a retiree. Dependent children must be under 26 years of age. Attach a separate sheet if needed to add additional dependents and include all the information below.

Name (Last, First, M.I.)	Social Security Number	Birth Date	Sex	Relationship (Spouse, Child)
			☐ M ☐ F	
			☐ M ☐ F	
			☐ M ☐ F	
			☐ M ☐ F	

I am hereby electing the coverage as indicated on page 1 for myself and the eligible dependents listed above, if any.

I acknowledge that the vision insurance premium shown for my election will be deducted from my sick leave entitlement and paid to LifeMap. If I have no sick leave entitlement or if my sick leave entitlement has been exhausted, I authorize PERSI continue my coverage by withholding the required premium from my retirement allowance for each month I am entitled to a retirement benefit, until otherwise notified in writing.

I understand the rates and benefits are all subject to the master Group Policy maintained by Independent School District of Emmett #221 and LifeMap and may change. If the premium changes, I authorize PERSI to deduct and pay the new premium amount.

I understand that my coverage may be terminated if Independent School District of Emmett #221 ceases to insure retired employees under a group vision insurance policy issued by LifeMap; I cease to be eligible for PERSI benefits; or I elect to terminate my coverage. Once my PERSI benefits are exhausted, I may be provided with a Direct Billing option by LifeMap to continue my coverage as elected.

I understand that I should contact PERSI prior to returning to work for a PERSI employer, as it may lead to suspension of my retiree benefits.

Retiree Signature _____

Date Signed _____

LifeMap Assurance Company®
200 SW Market Street
P.O. Box 1271, M/S E8L
Portland, OR 97207-1271
www.LifeMapCo.com
(800) 794-5390

Independent School District of Emmett #221– ID03898I

PERSI BILLED RETIREE LIFE ENROLLMENT CHANGE FORM

****INSTRUCTIONS****
Please print when completing ALL entries.
Upon completion, please send to **LifeMap Assurance Company (LifeMap) AND your Benefits Administrator**:

LifeMap Assurance Company
Attn: Billing
P.O. Box 1271, MS E8L
Portland OR 97207-1271

AND

Independent School District of Emmett #221
Attn: Benefits Administrator
119 N Wardwell Ave, Emmett, ID 83617

TO BE COMPLETED BY EMPLOYER/SCHOOL DISTRICT

Employee's Retirement Date:_____ Retiree Effective Date: _____ Class:_____

_____ _____
Signature of School District Benefits Administrator **Date Signed**

General Information (to be fully completed)

Retiree's Name (Last, First, MI)	☐ M ☐ F	Date of Birth
Social Security Number	Telephone Number	
Mailing Address: Street / Apt #	City	State / Zip
Email Address		

Please note: Coverage must be elected within 31 days of retirement. You must have elected dependent life coverage as an active employee to continue dependent life coverage as a retiree. Benefit changes are not allowed after initial election.

Retiree Coverage Election / Monthly Premium Rate (Retiree must elect an option below)

☐ $30,000 Option 1 / $82.50
☐ $20,000 Option 2 / $55.00
☐ $10,000 Option 3 / $27.50
☐ $5,000 Option 4 / $13.75

I am hereby electing the coverage indicated above. I acknowledge that the life insurance premium will be deducted from my sick leave entitlement and paid to LifeMap. If I have no sick leave entitlement or if my sick leave entitlement has been exhausted, I authorize PERSI continue my coverage by withholding the required premium from my retirement allowance for each month I am entitled to a retirement benefit, until otherwise notified in writing.

I understand the rates and benefits are all subject to the master Group Policy maintained by Independent School District of Emmett #221 and LifeMap and may change. If the premium changes, I authorize PERSI to deduct and pay the new premium amount.

I understand that my coverage may be terminated if Independent School District of Emmett #221 ceases to insure retired employees under a group life insurance policy issued by LifeMap; I cease to be eligible for PERSI benefits; or I elect to terminate my coverage. I understand that I should contact PERSI prior to returning to work for a PERSI employer, as it may lead to suspension of my retiree benefits.

Retiree Signature _____

Date Signed _____

Complete the following Beneficiary Designation Form and provide to your Benefits Administrator and LifeMap.

LifeMap Assurance Company®
LifeMapCo.com
(800) 794-5390

Beneficiary Designation Form
PERSI Billed Retiree

The definition of a Spouse includes your legal husband or wife. Please contact your employer for any additional eligibility requirements.

Please print in blue or black ink; complete all information requested.

Employer Name			**Group Number**
Independent School District of Emmett #221			**ID03898I**
☐ New Designation ☐ Change of Existing Designation			
Retiree's Name (Last, First MI)	Date of Birth	☐ M ☐ F	Social Security Number

Primary Beneficiary (Last, First MI)	Date of Birth	☐ M ☐ F	Social Security Number
Beneficiary Address (Street, City, State and Zip)	Relationship To You		**Benefit %**
Primary Beneficiary (Last, First MI)	Date of Birth	☐ M ☐ F	Social Security Number
Beneficiary Address (Street, City, State and Zip)	Relationship To You		**Benefit %**

If Primary Beneficiary(ies) dies before you, the benefit will be paid to your Contingent Beneficiary(ies).

Contingent Beneficiary (Last, First MI)	Date of Birth	☐ M ☐ F	Social Security Number
Beneficiary Address (Street, City, State and Zip)	Relationship To You		**Benefit %**
Contingent Beneficiary (Last, First MI)	Date of Birth	☐ M ☐ F	Social Security Number
Beneficiary Address (Street, City, State and Zip)	Relationship To You		**Benefit %**

If you wish to name additional beneficiaries, please attach a separate piece of paper with all of the necessary information, including the date and your signature.

The above beneficiary designation applies to:

☐ Retiree Life coverage with LifeMap

Sign, date and return this form to your Benefits Administrator.

Signature of Retiree	**Date Signed**

This form is not valid until SIGNED AND DATED and returned to your Benefits Administrator and LifeMap

LifeMap®

Independent School District of Emmett #221 – ID03898I

PERSI BILLED RETIREE VISION ENROLLMENT CHANGE FORM

(continued)

Dependents to be enrolled: You must have elected dependent vision coverage as an active employee to continue dependent coverage as a retiree. Dependent children must be under 26 years of age. Attach a separate sheet if needed to add additional dependents and include all the information below.

Name (Last, First, M.I.)	Social Security Number	Birth Date	Sex	Relationship (Spouse, Child)
			☐ M ☐ F	
			☐ M ☐ F	
			☐ M ☐ F	
			☐ M ☐ F	

I am hereby electing the coverage as indicated on page 1 for myself and the eligible dependents listed above, if any.

I acknowledge that the vision insurance premium shown for my election will be deducted from my sick leave entitlement and paid to LifeMap. If I have no sick leave entitlement or if my sick leave entitlement has been exhausted, I authorize PERSI continue my coverage by withholding the required premium from my retirement allowance for each month I am entitled to a retirement benefit, until otherwise notified in writing.

I understand the rates and benefits are all subject to the master Group Policy maintained by Independent School District of Emmett #221 and LifeMap and may change. If the premium changes, I authorize PERSI to deduct and pay the new premium amount.

I understand that my coverage may be terminated if Independent School District of Emmett #221 ceases to insure retired employees under a group vision insurance policy issued by LifeMap; I cease to be eligible for PERSI benefits; or I elect to terminate my coverage. Once my PERSI benefits are exhausted, I may be provided with a Direct Billing option by LifeMap to continue my coverage as elected.

I understand that I should contact PERSI prior to returning to work for a PERSI employer, as it may lead to suspension of my retiree benefits.

Retiree Signature _____

Date Signed _____

Instructions for Completing Your Beneficiary Designation

The Primary Beneficiary receives the benefit proceeds selected above upon your death. You may have more than one Primary or Contingent Beneficiary. **If so, please provide all requested information, and the percentage of proceeds you would like each Beneficiary to receive.** The Contingent Beneficiary(ies) receives proceeds only if the Primary Beneficiary(ies) dies before you. If no beneficiary is named, or no beneficiary survives the insured, settlement will be made in accordance with the terms of your Group Policy. Please provide all requested information.

Examples follow:

A. **One Primary Beneficiary:** Mary R. Jones – 100% (list information)

B. **Two or more Primary Beneficiaries:** 50% to John Jones and 50% to Sally Smith (list information for both)

C. **Two or more Primary Beneficiaries in Unequal Shares:** 75% to John Jones and 25% to Sally Smith (list information for both)

D. **One Primary and Contingent Beneficiary:** 100% to Mary R. Jones, if living, otherwise to Sally Smith (list info. for both)

E. **Trustee:** Mary R. Jones, Trustee, under trust agreement dated ___

F. **Insured's Estate:** My Estate

Under items B. and C. above, if one of the Primary Beneficiaries dies before you, 100% of the proceeds will go to the living Primary Beneficiary(ies).

Do you know that if death occurs and a minor (a person not of legal age) is the beneficiary, it may be necessary to have a Guardian of the Estate of the minor, or a Conservator for the minor appointed before any death benefit can be paid? This means legal expenses for the beneficiary and delay in the payment of the insurance. Please take this into consideration when naming your beneficiary.

If you have any questions, please see your Benefits Administrator.