SUMMARY FORM

I am retiring from University of Wyoming (500) **Printed Name** _____

Agency Name & Number **SSN** _____

MBI _____

My last working day is/was _____ **My Years of Service:** _____

Address: _____

_____ **My DOB:** _____

Phone Number: _____

I wish to continue the following benefits when I retire (Please indicate the coverage you will continue and complete the application):

_____ Health
_____ Preventive Dental Only
_____ Preventive & Optional Dental
_____ Life
_____ Dependent Life
_____ Vision
_____ Ambulance

Please indicate the appropriate payment method from the following options.

☐ I have the necessary funds available from my Wyoming Retirement System pension check and will be having the insurance premiums deducted monthly. I'm enclosing my personal check in the amount of $_____ made payable to the State of Wyoming to cover the one month it will take to establish my deductions.

☐ I am receiving a Board Retirement and have the necessary funds available from my Wyoming Retirement System pension check to pay the balance due and will be having the insurance premiums deducted monthly. I am enclosing my personal check in the amount of $_____ made payable to the State of Wyoming to cover the one month it will take to establish my deductions.

☐ I am receiving a Board retirement and my retirement program is with TIAA-CREF; am taking a lump sum retirement, or am not drawing retirement at this time. I will be paying the balance due of my premium to the University of Wyoming and will be included on the cash list.

☐ I am being affected by the State's Reduction in Force (RIF) and will be receiving the State contribution for the next six (6) months, in accordance with W.S.9-3-105(b). After the six (6) months, I will be eligible to receive State retirement insurance benefits and I request to have those premiums deducted from my retirement check beginning (the date RIF benefits end).

☐ I am taking a lump sum retirement, do not have enough money in my retirement check to cover my premiums, my retirement program is with TIAA-CREF, or I am not drawing retirement at this time. I will be paying the premiums by automatic withdrawal from my checking or savings account.

I understand and agree that by electing to participate as a retiree on the State of Wyoming insurance plans, I am waiving my rights to continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

**** NOTE**: If your dependents subsequently become ineligible for dependent coverage due to divorce, age, or other qualifying event, they may have a right to continue coverage under COBRA for a limited amount of time. Please notify Employees' Group Insurance if you have a qualifying event.

I understand that the election of insurance coverage I have made (above) will continue and appropriate deductions for premium is authorized until I notify the Employees' Group Insurance Office, in writing, to cancel the insurance and that canceled coverage is not reinstatable.

_____ _____
Signature of Employee Date

_____ _____
Signature of Spouse Date

Cancelation Policy: Coverage will be canceled on the last day of the month that written notice is received by EGI. Please remember that once coverage has been canceled; there is no opportunity for reinstatement.