



# Retiree Benefit Election Form

Congratulations on your upcoming retirement!

**Here are the next steps:**

1. If you have a Flexible Spending Account, you must use the remaining funds within 90 days of retirement
2. Select health and dental insurance options below
3. For spouse/family or dental coverage, complete the Electronic Funds Transfer (EFT) Authorization Form
4. Return forms to HR before your last day of work

Employee ID #: \_\_\_\_\_

EE Type:   Admin / Faculty / PSRP

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Early Retiree     Normal Retiree

Retirement Date: \_\_\_\_\_

Retiree Ins Cov Effect Date: \_\_\_\_\_

## Health & Dental Insurance Elections

- Yes, I DO wish to receive retiree health and/or dental benefits (select your plan below)\*
- *It is not possible to switch between health insurance plans at retirement – changes can only be made during Open Enrollment once per year.*
  - *If you are purchasing coverage for your spouse and do not have any dependents, please select two single plans below and complete a new application. The family plan is more expensive.*
- No, I DO NOT wish to receive retiree health or dental benefits
- I would like to DEFER my retiree health and dental benefits to a later date because my spouse carries Madison College health insurance and is still an active employee

Retiree Health & Dental Plans*	Retiree (single plan)	Spouse (single plan)	Family Plan (with dependents)
Health - Arise – HMO Network	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health - Dean - HMO Network	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health - GHC-SCW – HMO Network	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health - WPS Statewide - PPO Network	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental - Delta (100% paid by retiree)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

\*Early retirees are eligible to receive Madison College health insurance benefits until they become eligible for Medicare. Madison College pays the full monthly premium for single early retiree health insurance coverage. Dental coverage is paid by the retiree and can continue after Medicare eligibility. Retirees may also purchase additional health and dental insurance coverage for spouse or family.

Electronic funds transfer (EFT) is required for insurance premiums. Monthly deductions are made on the 10th of each month. If the 10th falls on a weekend, the deduction will take place the following business day.



# Electronic Funds Transfer (EFT) Authorization Form for Health/Dental Premiums

**Please attach a voided check or savings deposit slip**

Purpose for completing this form:  Original sign up  Authorization change

## Retiree Information

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

## Bank Information

Name of Financial Institution: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

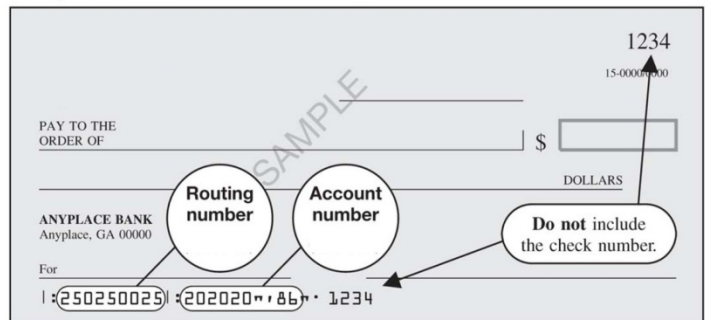
Bank Routing Number: \_\_\_\_\_

Account to Debit:

Checking Account Number:  
\_\_\_\_\_

Savings Account Number:  
\_\_\_\_\_

### Sample Check



## Authorization

I hereby authorize Madison Area Technical College to initiate debit entries to my checking/savings account at the depository financial institution named above and to debit the same such account. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. This authority will remain in effect until I notify in writing to cancel it in such time as to afford the financial institution a reasonable opportunity to act on it. I can stop payment of an entry by notifying my financial institution three (3) days before my account is charged. If any of the above information changes, I will promptly complete a new electronic funds transfer (EFT) authorization form.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_