RETIREE NOTIFCATION FORM
Group Health Coverage

Employee's Full Name (Last, First, Middle):_____

Employee #:_____ Birth Date (MM/DD/YYYY): _____

Address: _____
City, State, Zip

Contact #: _____ Retirement Date: _____

Department: _____ Title: _____

☐ Yes ☐ No Are you retiring under the Texas Municipal Retirement System?

☐ Yes ☐ No Have you been continually employed with the City of Stephenville for the last five years?

☐ Yes ☐ No Do you have other group health insurance available to you?

☐ Yes ☐ No Does your spouse or covered dependents have other group health insurance available to them?

☐ Yes ☐ No Do you agree to inform the City of Stephenville if you or a covered member of your family become covered under another group health plan or entitled to Medicare?

☐ Yes ☐ No Do you understand that premium amounts will change from year to year?

☐ Yes ☐ No Do you understand that you are responsible for remitting the full amount of the premium by a specific date, and if you fail to remit the required amount coverage will terminate for you and your dependents?

Declination

_____ (Initial) I understand that I am eligible for group health coverage continuation: however, I hereby decline retiree health coverage. I understand that this is the only opportunity I will have to continue the City's group health coverage.

I understand that I also have the right to continue coverage subject to COBRA provisions for up to 18 months, and this declination will not jeopardize those rights under COBRA.

I certify by signature below that I have read the retirement provisions described in the Stephenville Policy manual.

_____ _____

Employee Signature Date