Retiree Group Benefits Enrollment Packet

Congratulations on your retirement from JACKSON COUNTY SCHOOL DISTRICT.

JACKSON COUNTY SCHOOL DISTRICT offers group dental and vision benefits to its active benefit eligible employees. Employees that are currently participating in either the group dental and/or vision plans are able to continue coverage into retirement - as long as your monthly premiums are paid current and JACKSON COUNTY SCHOOL DISTRICT continues to offer the group plan(s) to its active benefit eligible employees.

Once you separate employment with JACKSON COUNTY SCHOOL DISTRICT as a qualified Retiree, you have **thirty-one (31) days** from your last date of employment with JACKSON COUNTY SCHOOL DISTRICT to elect to continue your coverage in either one of these group dental and vision plans. **If you do not make the election within the thirty-one (31) days, you will have permanently waived your eligibility to participate in these group plans as a qualified retiree of JACKSON COUNTY SCHOOL DISTRICT.**

As a retiree participant in a group plan, your monthly premium payments must be provided through an authorized bank draft process that is established through our benefit plan administration service provider National Insurance Marketing Brokers (Dba AmeriLife Benefits). This packet includes the Retiree Benefit Enrollment Forms for both the dental and vision plans as well as the Bank Draft Agreement. In order to continue your participation with one or both plans, you must complete the applicable enrollment form(s) and Bank Draft Authorization and submit them along with a voided check. National Insurance Marketing Brokers will process your election to continue your dental and/or vision coverage as a retiree participant in the plan(s).

Please submit your completed forms by mail to:

National Insurance Marketing Brokers, LLC
ATTN: Premium Billing Department
4551 West 107th St, Suite 310
Overland Park, KS 66207

Should you have any questions or need assistance at any time regarding your retiree benefits or premium payments, please contact AmeriLife Benefits directly at: **(877) 523-0176**

We thank you for your past service to our organization and wish you the best in your retirement!

Best regards,

Employee Benefits and Services

JACKSON COUNTY SCHOOL DISTRICT

Jackson County School District

Retiree Benefits - Dental Enrollment Form

This election form, along with the Direct Deposit Authorization form, must be completed and returned within 30 days of your coverage end date. Election forms that are postmarked outside of this timeframe will not be accepted.

Group Dental Plan Carrier Name:	Group Policy #:	Plan Anniversary Date:	Plan Rates Good Through:
MetLife	218756	January 1st	12/31/2023

Step 1: Retiree Dental Plan Participant Information

Retiree / Participant Full Name:	Social Security Number:
Home Mailing Address:	
Primary Phone Number:	Personal Email:
Date of Retirement from Group:	Effective Date of Retiree Coverage:

Step 2: Retiree Enrollment in Group Sponsored Dental Plan

Enter information below for each person enrolling in the group sponsored dental plan. Line 2 is reserved for spouse; leave blank if spouse is not enrolling in a plan. Step 3 will allow you to indicate your chosen dental plan option.

Relationship (Self, Spouse, Child)	Retiree / Participant Name	SSN	Date of Birth	Marital Status (M/S)	Gender
SELF		See Above			M / F
SPOUSE					M / F
CHILD					M / F

Step 3: Selection of Retiree Dental Plan Option & Coverage Tier

☐ Gold Plan				☐ Platinum Plan			
Monthly Premiums				Monthly Premiums			
☐ Retiree	$22.32	☐ Retiree + Child(ren)	$49.10	☐ Retiree	$39.50	☐ Retiree + Child(ren)	$86.84
☐ Retiree + Spouse	$44.60	☐ Retiree + Family	$72.56	☐ Retiree + Spouse	$78.96	☐ Retiree + Family	$126.18

I certify the information above is true and correct, and I have reviewed my enrollment information. My listed dependents (if any) are eligible for coverage under the plan, and may be subject to validation of documents proving eligibility, including the potential removal of any ineligible dependents from the plan. I agree that I may only change or drop my coverage under the plan if I have a qualifying life event, or at time of the next open enrollment period as defined by the sponsoring group.

_____ _____

Retiree Participant Signature **Date**

Jackson County School District

Retiree Benefits - Vision Enrollment Form

This election form, along with the Direct Deposit Authorization form, must be completed and returned within 30 days of your coverage end date. Election forms that are postmarked outside of this timeframe will not be accepted.

Group Vision Plan Carrier Name:	Group Policy #:	Plan Anniversary Date:	Plan Rates Good Through:
MetLife	218756	January 1st	12/31/2023

Step 1: Retiree Vision Plan Participant Information

Retiree / Participant Full Name:	Social Security Number:
Home Mailing Address:	
Primary Phone Number:	Personal Email:
Date of Retirement from Group:	Effective Date of Retiree Coverage:

Step 2: Retiree Enrollment in Group Sponsored Vision Plan

Enter information below for each person enrolling in the group sponsored dental plan. Line 2 is reserved for spouse; leave blank if spouse is not enrolling in a plan. Step 3 will allow you to indicate your chosen dental plan option.

Relationship (Self, Spouse, Child)	Retiree / Participant Name	SSN	Date of Birth	Marital Status (M/S)	Gender
SELF		See Above			M / F
SPOUSE					M / F
Child					M / F

Step 3: Selection of Retiree Vision Plan Option & Coverage Tier

☒ **Standard Plan**							
Monthly Premiums				Monthly Premiums			
☐ Retiree	**$6.92**	☐ Retiree + Child(ren)	**$12.46**	☐ Retiree	**N/A**	☐ Retiree + Child(ren)	**N/A**
☐ Retiree + Spouse	**$14.13**	☐ Retiree + Family	**$19.38**	☐ Retiree + Spouse	**N/A**	☐ Retiree + Family	**N/A**

I certify the information above is true and correct, and I have reviewed my enrollment information. My listed dependents (if any) are eligible for coverage under the plan, and may be subject to validation of documents proving eligibility, including the potential removal of any ineligible dependents from the plan. I agree that I may only change or drop my coverage under the plan if I have a qualifying life event, or at time of the next open enrollment period as defined by the sponsoring group.

_____ _____

Retiree Participant Signature **Date**

AUTHORIZATION AGREEMENT FOR DIRECT DEBIT OF ACCOUNT

NIMBL

NATIONAL INSURANCE MARKETING BROKERS, LLC

Covered Insureds Full Name:	**Name of Employer / Group:** Jackson County School District
Home Address (City, State, Zip):	
Email Address:	**Phone Number:**

Purpose for submitting this authorization (Check appropriate option):

☐ New Direct Debit Payment Plan - I am initiating a recurring debit from a checking or savings account

☐ Change to Existing Direct Debit Payment Plan - I have a change to my Account and/or my Financial Institution

☐ Cancellation of Existing Direct Debit Payment Plan - I wish to cancel my participation

Bank account to be debited is: (Check appropriate box):

☐ Personal Checking Account ☐ Personal Savings Account

Name of Financial Institution:	
Address & Phone Number of Financial Institution:	
Routing Number (ABA):	**Account Number:**

YOU MUST ATTACH A VOIDED CHECK

- The amount due each month for your participating group insurance lines of coverage is automatically deducted from your banking account on the 15th of each month, unless written authorization is received canceling participation of the direct debit.
- National Insurance Brokers, LLC will notify you of any changes to the rate(s) associated with your participating group plan coverage held under the sponsoring groups master policy that may occur at the end of the plan anniversary.
- Please be advised that if you choose a Savings or Money Market Account, your financial institution may limit the number of transactions and assess a fee for exceeding the limit or decline the direct debit authorization. Please contact your financial institution for further information.
- Please allow up to four (4) weeks for your request to be processed. You are responsible for payment until this direct debit service is established.
- All Returned Direct Debit Authorizations are subject to a $37.00 fee. Should a participating member have more than one (1) Returned Direct Debit Authorization, National Insurance Marketing Brokers, LLC reserves the right to remove the member from the Direct Debit Payment Plan.

☐ **I authorize National Insurance Marketing Brokers, LLC to start drafting my payments on the first payment due date, including any past due balance that is owed for my participating group insurance lines of coverage.**

APPLICANT AUTHORIZATION STATEMENT:

As a convenience to me, I hereby request and authorize you to pay and charge to my account; drafts drawn on my account by and payable to National Insurance Marketing Brokers, LLC, provided there are sufficient funds in said account to pay the same on presentation. Such drafts will bear my printed name. If at any time should the premiums that are owed for my participating lines of coverage increase or decrease, due to a rate or coverage change from a qualifying event or during annual open enrollment, I authorize National Insurance Marketing Brokers, LLC to adjust my monthly draft amount accordingly. This authorization shall remain in effect until revoked by me in writing, and until you actually receive such notice, I agree that you shall be fully protected in honoring any such draft. I agree that your rights in respect to any such draft shall be the same as if it were a check signed personally by me. I further agree that if any such draft is dishonored, whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

Signature of Depositor (as it appears on account) **Date**

NATIONAL INSURANCE MARKETING BROKERS, LLC
4551 W. 107th St. Suite #310
Overland Park, KS 66207
Phone (877)523-0176 or Fax (844)665-7638

THIS FORM MUST BE COMPLETELY FILLED OUT & SENT IN TO BE ACCEPTED