Syracuse University
Human Resources

Opt Out Retiree Medical Form

Return this form to:
HR Service Center
hrservice@syr.edu
Phone 315.443.4042 Fax 315.443.1063
Skytop Office Bldg., Suite 101, Syracuse, NY 13244

Purpose of this Form - This form allows retirees and dependents who are eligible for the Opt Out/Opt In Coverage Options under the Syracuse University Retiree Medical Benefits Plan, and if applicable, the Syracuse University Retiree Prescription Drug Plan, to opt out of coverage under the Plan(s) in a way that will allow them to later opt back into coverage under the Plan(s), as long as they have satisfied the applicable Plan requirements. Information about who is eligible for the Opt Out/Opt In Coverage Options is described in the Plans, and is available by contacting the Office of Human Resources.

This form can be used by an eligible retiree and/or an eligible dependent to opt out of coverage under the Plan(s). If an eligible dependent of a retiree is opting out of Plan coverage, the retiree information in number 1 below must be provided (even if the retiree is not electing to opt out of Plan coverage). If more than one eligible dependent wishes to opt out of coverage under the Plan, a separate form must be completed by each such dependent.

1. Information about the Retiree Participating in the Plan:

Full Name: _____
(Last, First, Middle Initial)

Date of Birth: _____ SU ID Number: _____

Address: _____

Phone number: _____

Check whether retiree wishes to elect out of coverage under the Plan:
☐ Yes ☐ No ☐ Currently in Opt Out Status

If "Yes," requested effective date of Retiree's Opt Out Election*

_____

Check if you are eligible for the Voluntary Separation Incentive Program ("VSIP"), and would like to retain the ability to apply the VSIP subsidy credits at a later date. All unused subsidies expire on 12/31/21.

☐ Yes, I am eligible ☐ No

2. Information about the Dependent Who Wishes to Opt Out of Coverage under the Plan (If Applicable):

Full Name: _____
(Last, First, Middle Initial)

Relationship to retiree: _____

Date of birth: _____

Phone number: _____

Address if different from retiree: _____

Requested effective date of dependent's opt out election*:

_____

***Effective Date of the Opt Out Election:** The effective date can be no sooner than the first day of the month following receipt and approval of this form by the Office of Human Resources.

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Conditions For Opting Back In the Plan: A retiree and/or dependent who has satisfied the eligibility requirements for the Opt Out/ Opt In Coverage Option under the Plans ("Eligible Individual") and who wishes to later opt back into one or both Plans must satisfy the following requirements (as well as other requirements specified in each applicable Plan and by the Office of Human Resources):

- **Not Eligible for Medicare** - If the Eligible Individual is not eligible for Medicare on the date selected for opting back into coverage under the applicable Plan, he or she can opt back into coverage under the Plan **only if, among other things, he or she can provide written proof of continuous medical coverage for the entire period that he or she was not covered by the Plan as a result of the opt out election** (such proof must be provided in such form and manner as is specified by the Office of Human Resources). There generally is no limit on the number of times an Eligible Individual can opt in under a Plan under this eligibility requirement.
- **Eligible for Medicare** - If the Eligible Individual is eligible for Medicare on the date selected for opting back into coverage under a Plan and has not become ineligible for coverage under any other provision of the Plan, he or she may opt back in the Plan one time without providing proof of continuous coverage. An Eligible Individual still would have to provide certain other documentation (such as proof of coverage under Medicare Parts A and B).

3. **Timing Of An Opt In Election:** An Eligible Individual who has satisfied a Plan's requirements for opting back into coverage under the Plan may only opt in:
   - once per year during an open enrollment period for the Plan;
   - within 31 days following the date when the Eligible Individual experiences a qualifying event that results in him or her losing medical or prescription drug coverage (whichever is applicable) and that satisfies such other requirements as are specified by the Office of Human Resources (he or she also will have to, among other things, provide written proof of the qualifying event in such form and manner as is specified by the Office of Human Resources); or
   - within 31 days following the date when the Eligible Individual becomes eligible for Medicare (he or she also will have to, among other things, provide written proof of eligibility for Medicare that is acceptable to the Office of Human Resources).

4. **Certification:** The retiree described in number 1 above who is electing to opt out of coverage under the Plan, and any dependent described in number 2 above, must sign and date the form in the spots indicated below, and by such signing, is certifying that they understand the guidelines dictated by the Plans.

Retiree Signature: _____ Date: _____

Dependent Signature (If Applicable): _____ Date: _____

HR Service Center Review (Internal Use Only):

☐ Approved ☐ Denied If denied, reason(s) for denial: _____

HR Processed Date: _____

Effective Date of Opt Out: _____