Human Resources Department

Madison Municipal Building, Suite 261
215 Martin Luther King, Jr. Boulevard
Madison, Wisconsin 53703
Phone: (608) 266-4615
Fax: (608) 267-1115
hr@cityofmadison.com
www.cityofmadison.com/hr

CITY OF MADISON GROUP TERM LIFE INSURANCE PLAN

LIFE INSURANCE AT RETIREMENT

SECTION 1: EMPLOYEE INFORMATION

Print Name _____

Date of Retirement _____

SECTION 2: CONTINUE COVERAGE (Complete only if CONTINUING life insurance coverage at retirement)

☐ ***I wish to continue my life insurance coverage in retirement.***

I understand that quarterly bills for life insurance premiums will be mailed to me at my home until I reach age 65, and that failure to pay my life insurance premiums by the due date will result in cancellation of my life insurance coverage. I understand that if my life insurance coverage is canceled there will be no opportunity to re-enroll with the City of Madison's Group Term Life Insurance Plan (If coverage under the Plan is terminated for a reason other than failure to pay the required premium, a retiree and retiree's dependents may have the right to apply for an individual conversion policy if an application for coverage is completed within 31 days of termination of coverage).

_____ _____

Signature **Date of Signature**

Mailing Address _____

_____

Continuation of Dependent coverage: An employee who has elected dependent life insurance units of coverage may continue dependent coverage in retirement. The retiree's spouse may have coverage to age 65; the retiree's child may have coverage to age 21 (or age 25 if the child is a full-time student). The cost of coverage—currently $1.75 per unit per month—will be billed to the retiree by the City either quarterly (if the retiree is under age 65) or annually (if the retiree is over age 65). Dependent coverage ends when the spouse reaches age 65 or dependent child reaches age 21 (or as late as 25, if a full-time student) or if the premium is not paid by the due date. A spouse or dependent may have the right to apply for an individual conversion policy within 31 days of when eligibility for coverage under the group life insurance program ends due to age or student status.

☐ ***I wish to continue my dependent life insurance coverage in retirement.***

Name of Last Eligible Spouse/Dependent: _____

Last Eligible Spouse/Dependent Date of Birth: _____

STOP HERE IF CONTINUING COVERAGE

SECTION 3: CANCEL COVERAGE (Complete only if CANCELING life insurance coverage at retirement)

☐ ***I <u>do not</u> wish to continue my life insurance in retirement.***

I understand that no future enrollment opportunity will be available to me.

_____ _____

Signature **Date of Signature**

Original: Retiring Employee's Human Resources File Copy: Retiring Employee