saif

2026 RETIREE ENROLLMENT FORM

Mail or email this form to: **ASI COBRA, P.O. Box 657, Columbia, MO 65205**
OR: **Email completed for to: cobra@asicobra.com**

Last name:	First name:		
Mailing address: Street or PO Box, City, State, Zip Code			
Home phone:	SSN:	E-mail address:	Marital status:

Reason for completing this form: *(check all that apply)*

☐ New enrollment ☐ Open Enrollment ☐ Change of address ☐ Add dependent(s) ☐ Delete dependent(s)
☐ Delete medical coverage ☐ Delete dental/vision coverage ☐ Delete Health & Wellness Center coverage
☐ Delete Lyra mental health program coverage

Medical Effective date: _____

☐ Providence PPO plan (107689)

☐ Providence PPO Early Retiree plan (107689)

☐ Kaiser HMO plan (01816-AC-10)

Dental Effective date: _____

☐ Delta Dental (1919-12)
☐ Kaiser DHMO Dental (01816-AC-10)
☐ Kaiser PPO Dental Choice (01816-AC-10)
☐ Willamette Dental Group (OR223)

Vision Effective date: _____

If you're enrolling in a dental plan, you are required to enroll in a vision plan

☐ VSP Base Plan ☐ VSP Buy-up Plan

Health & Wellness Center

☐ Yes ☐ No (Enrolled automatically if enrolled in a medical plan)

Lyra mental health program

☐ Yes ☐ No ☐ Retiree and eligible dependents ($26.77/month)

LIST YOU, SPOUSE OR DOMESTIC PARTNER, AND ELIGIBLE DEPENDENTS WHO ARE TO BE COVERED.

NOTE: These fields are required, incomplete forms will be returned. The coverage level you select for dental must match your vision enrollment (e.g. if you enroll yourself and spouse in dental you must enroll yourself and spouse in vision).

Relationship	Last name	First name	SSN #	Birthdate	Gender	Coverage
Self						SELECT
						SELECT
						SELECT
						SELECT

Coordination of Benefits information for above family members:

Does another group plan cover **you and/or your dependents?** Yes ☐ No ☐ If yes please indicate:

Name of person with other plan: _____

Insurance Carrier: _____ Group #: _____ Member ID #: _____

Names of individuals covered: _____

I have read the health benefits enrollment materials and understand and agree to the eligibility requirements and other terms indicated on the reverse side of this form. **I will remit the correct premium for the benefits I have selected.**

_____ _____

Retiree signature or Retiree electronic signature Date

RETIREE ENROLLMENT APPLICATION

By my signature on the Enrollment Form, I am hereby applying for enrollment under SAIF's health benefits plan for myself and my eligible family members as listed on the Enrollment Form. I authorize any hospital or health care provider to furnish the carrier with information relating to illness, injury or conditions for which benefits are claimed under the selected plans. Likewise, I, or my duly authorized representatives, authorize such medical information be disclosed to such carriers or intermediaries as is necessary to determine entitlement to benefits under the Social Security Act of 1965 (Public Law 89-97), including the amendments thereto.

ENROLLMENT AND ELIGIBLE DEPENDENTS

Retirees may elect any of the available medical, dental and vision plans regardless of what plan they were enrolled in as an active employee. Changes to these plans may also be made during open enrollment.

Eligible dependents include:

- Legally married spouse, registered domestic partner, or unregistered domestic partner. Unregistered domestic partners must meet the definition of a domestic partner based on criteria established by the plan providers.
- Dependent children to age 26 who are natural children, step-children, children of a domestic partner, a child placed for or pending adoption, and a legally adopted child.
- Dependent children who are incapable of self-sustaining employment because of a physical or mental disability. Such children may be eligible to remain covered even though they are over 26. To be eligible, the disability must have occurred before a child's 26th birthday (additional affidavit will be required; contact ASI COBRA).
- Dependent's newborn child will be covered for 31 days after it is born.
- A child by affidavit includes, but is not limited to, a foster child, grandchild, child placed for adoption, or court ordered placement of a child who lives in the household of the eligible Retiree, and is the Retiree's IRS dependent. Coverage ends the last day of the month in which the court ordered guardianship ends or age 18, whichever comes first.

MAKING COVERAGE CHANGES OR ADDING DEPENDENTS

As a SAIF Retiree enrolled in the retiree health plan(s), you may make changes in your coverage only during a plan change period (e.g. open enrollment) or within 60 days of a qualified status change. You may not, however, add medical or dental/vision coverage if you had not selected it at the time of retirement.

You may obtain health coverage for a newly acquired or newly eligible dependent by notifying ASI COBRA within 60 days of the qualifying event. Changes to dependent coverage during the plan change period are not allowed unless there has been a qualifying event.

You are responsible for dropping newly ineligible dependents from the plan by submitting an enrollment form to ASI COBRA within 30 days from the date the dependent loses eligibility.

If at any time you or your covered dependent decides to cancel coverage under any plan, there will be no option to re-enroll at a later date.

COVERAGE TERMINATION

Retiree coverage ends once you are eligible for Medicare. Coverage for a divorced spouse will terminate the end of the month in which the divorce is final. Written notification must be sent to ASI COBRA. Coverage for a domestic partner will terminate at the end of the month in which a Statement of Termination of Domestic Partnership is filed with ASI COBRA. Dependent children will be removed from coverage the end of the month in which eligibility is lost.

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