SOUTH DAKOTA state employee benefits program learn. act. thrive.

Application to Continue Benefits—Retiree Health

South Dakota State Employee Benefit Program
500 East Capitol Avenue Pierre, SD 57501-5070
Phone: 605.773.3148 Fax: 605.773.6840
http://benefits.sd.gov

Name:_____ SSN or Insurance ID: _____
Last First MI

Mailing Address: _____
Street City State Zip Code

Date of Birth:____/____/____ Phone:_____ Email:_____

1) Health Election

❑ I **DO** elect to continue health coverage for myself or my eligible dependent(s)
❑ I **DO NOT** elect to continue health coverage for myself or my eligible dependent(s).
(Please complete the information above, sign and return this form.)

2) Please check the Health Plan desired. You must check ONE of the following:

☐ Low Deductible Health Plan ($1,000) ☐ High Deductible Health Plan ($2,000/$4,000)

3) Coverage

❑ Retiree Only
❑ Retiree & Spouse
❑ Spouse Only (Retiree only rate)
❑ Retiree & Child(ren)
❑ Family

4) Participant and/or dependent information for each person who will be continuing coverage:

Name	Birth Date	Social Security Number

5) Non-tobacco User or Tobacco User

❑ I am **not** a tobacco user
❑ I am a tobacco user
❑ My covered spouse is **not** a tobacco user
❑ My covered spouse is a tobacco user

6) Method of Payment

If you choose the Direct Payment Plan, the premiums for ALL products can be deducted from your bank account. However, the South Dakota Retirement System can withhold only Health Plan premiums.

❑ South Dakota Retirement System (Health Only)
❑ Direct Payment Plan (Fully complete the enclosed form and attach a voided check.)
❑ Deduct from my spouse's monthly SDRS benefits

My spouse's SSN#:_____ Spouse's Signature:_____

I authorize the South Dakota Retirement System (SDRS) to release to the South Dakota Bureau of Human Resources my address, phone number, and/or email on file for the purpose of the Bureau of Human Resources contacting me regarding my health insurance.

I represent that the foregoing information is, to the best of my knowledge and belief, accurate. I agree that to retain coverage, I (we) must abide by the Plan's provisions.

_____ _____
Applicant Signature **Date Signed**

SOUTH DAKOTA STATE EMPLOYEE HEALTH PLAN

FY19 PLAN YEAR

July 1, 2018 – June 30, 2019

Starting July 1, 2018, the following monthly premium rates will apply for Pre-65 Retiree Health Plan members:		
	Low Deductible Plan ($1,000)	**High Deductible Plan ($2,000/$4,000)**
Retiree only	**$2,013.91**	**$966.20**
Retiree + spouse	**$4,398.91**	**$1,803.53**
Retiree + child(ren)	**$2,533.80**	**$1,166.10**
Retiree + family	**$4,918.81**	**$2,003.42**
NOTE: Contributions for retiree and spouse coverage will increase $60.00 per person per month if retiree and/or covered spouse use tobacco.		