# Application to Continue Benefits—Retiree Health

**South Dakota State Employee Benefit Program**
**500 East Capitol Avenue Pierre, SD 57501-5070**
**Phone: 1.877.573.7347, option 2**
**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 ($850) ☐ High Deductible Health Plan ($1,800/$3,600)

## 3) Coverage

❑ Retiree Only ❑ Spouse Only (Retiree only rate) ❑ Retiree & Child(ren)
❑ Retiree & Spouse ❑ 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 ☐ My covered spouse is **not** a tobacco user
☐ I am 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

# FY18 PLAN YEAR

*July 1, 2017 – June 30, 2018*

| FY18 RETIREE MONTHLY CONTRIBUTION RATES | | |
|---|---|---|
| Coverage Level | Low Deductible Health Plan | High Deductible Health Plan (HSA Compatible) |
| Retiree | $1,484.00 | $711.97 |
| Retiree + Spouse | $3,241.45 | $1,328.98 |
| Retiree + Child(ren) | $1,867.10 | $859.27 |
| Family | $3,624.55 | $1,476.27 |
| *$60 per person, per pay period will be added to your Health Plan contribution if you and/ or your spouse use tobacco products | | |