



# 2026 Retiree Benefits Guide





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# Pre-Retirement Resources

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**Retiree Policy** - 59.5 years of age and 10 years of service

**TIAA Webinars** - Attend a live retirement webinar or view a recorded webinar available to you from TIAA by visiting [www.tiaa.org/webinars](http://www.tiaa.org/webinars). Webinar topics include:

- Social Security Basics
- Retiring in the New Normal
- Understanding Medicare

*All retirees with a 457b need to contact TIAA at 1-800-732-8353 or visit [www.tiaa.org/schedulenow](http://www.tiaa.org/schedulenow) to schedule an appointment. It is imperative that you contact TIAA within 30 days to discuss your options to avoid any possible penalties. If you have a 403b, we do advise you to contact TIAA to discuss your options.*

**My Social Security Account** - Anyone considering retirement should create a “My Social Security Account” located at <https://www.ssa.gov/myaccount/>. An account allows you to estimate future benefits, review your social security statements, and provide you with other personalized tools.

**To learn more about planning for retirement and social security please visit** <https://www.ssa.gov/prepare/plan-retirement>. Planning is the key to creating your best retirement and social security is just one part of your retirement plan. This site provides additional information on how benefits work, deciding when to start retirement and what could affect your retirement benefits.



# Retiree Checklist

✓	What to do...
	Determine your last day worked (must not be vacation, sick or holiday)
	Notify your Supervisor/Department Chair/Dean
	All retirees with a 457b need to contact TIAA at 1-800-732-8353 or visit <a href="http://www.tiaa.org/schedulenow">www.tiaa.org/schedulenow</a> to schedule an appointment. It is imperative that you contact TIAA within 30 days to discuss your options to avoid any possible penalties. If you have a 403b, we do advise you to contact TIAA to discuss your options.
	Visit <a href="http://medicare.gov/basics/get-started-with-medicare">medicare.gov/basics/get-started-with-medicare</a> to learn when to enroll in Medicare A and B

**Once Human Resources receives the appropriate paperwork from your department, notifying us of your retirement date, you will receive an email with the following information.**

## Staff

- Accrued vacation (up to 160 hours) will be paid out in your last check.
- Your benefits will cover you through the end of the month in which you work.

## Faculty

- Fulltime faculty have benefits coverage through the end of the month in which they are paid. This specific date can be found in your letter of agreement.

## Staff and Faculty

- Life Insurance Conversion - Retirees may apply to convert life insurance coverage within 31 days of their benefits end date.
- Voluntary Supplemental Insurance - Your current voluntary Wellfleet and AFLAC products can be continued, at the same rate, by contacting Wellfleet at 855-664-5838 or AFLAC at 336-991-4590.
- COBRA - If you are not ready to enroll in Medicare and the supplemental health plan, you may continue your Elon Group Health, Dental and Vision Insurance Plans by electing COBRA (generally for up to 18 months, dependents up to 36 months). See page 7 for rates.
- Supplemental Insurance (to Medicare) - Elon University will contribute \$100 per month on behalf of each retiree, who enrolls in the Benistar program. See pages 8 – 12 for coverage and rates.
- Meetings with TIAA - Individual meetings can be scheduled with representatives from TIAA to discuss matters regarding retirement contributions.
- Retiree Recognition - Faculty and staff are recognized at the end of the academic school year with a Faculty/Staff awards luncheon and Staff Appreciation Day. In addition, Elon presents you with a choice of a retirement gift. We have an array of gifts to choose from including the ones listed here.
  - Home-made rocking chair
  - Glass vase hand-made in Sweden
  - Classic 3-piece decanter set
  - French Staunton style chess set

# Benefits Available to Retirees

## Continuation of E-mail Usage

Retirees retain access to their Elon email, To-Do, and calendar via a web browser. Please note that if you have downloaded the Office suite to your personal computer, access will expire 30 days after the last date of employment. (Moodle and campus wireless access are not available)

- Retirees will continue to receive Announcements@elon.edu emails.
- Technology Service Desk can assist with transferring files and ownership of departmental data prior to your last day of employment by calling at 336-278-5200.

## Phoenix ID Card Use

The university's ID Card is the key to receiving many of the services provided to retirees. You will need to go to the Phoenix Card Office in Oaks/McCoy Commons 201 with your phoenix card so your card can be updated to reflect your retiree status. The card can be used for:

- **Belk Library** - Retired employees may continue to check out materials and use services of Belk Library with a Phoenix Card.
- **Fitness Center** - The Fitness Center can be used as long as you have a Phoenix card.
- **Cultural Events** - Retired employees with Phoenix ID cards can continue to secure tickets at no charge for university-sponsored programs. Contact the ticket office (336) 278-6750 for calendar and ticket info.
- **Athletic Events** - Admission to athletic events can be obtained through the use of the Phoenix ID card. Contact the athletic ticket office at (336) 278-6750 for schedule and ticket information.

## Continuation of Parking Permit Usage

All retired employees are entitled to keep their parking permit to park on the campus when they visit.

## Tuition Remission Program

Retired employees may enroll in one (1) course per semester. If you are interested in taking a course, contact the Office of Admissions to receive an application for special admission at (336) 278-3566. After speaking with Admissions, you will need to complete a tuition remission form that can be picked up in the Human Resources Office.

## Employee Discount Program

Retired employees are offered the same discounts with some local vendors as current employees. A current list of participating vendors can be found on The Office of Human Resources homepage at <http://www.elon.edu/e-web/bft/hr/discounts.xhtml>.

## Free Flu Vaccine

A flu vaccine is provided free of charge to retired faculty and staff each year at the same time it is provided to the campus community. Because the supply of flu vaccine is sometimes limited, the vaccine will be administered on a first come, first served basis.

## Reservation Privileges for the Lodge Property

The lodge property, located on Highway 100 in Elon, can be scheduled through Campus Recreation at (336) 278-7529.

# Benefits Available to Retirees Continued

## Invitations to Campus Events

Retired employees receive invitations to a number of campus events. They include programs such as the annual Faculty/Staff Awards luncheon when faculty members are recognized, Staff Appreciation Day when staff members of the year are recognized, and the university's annual Holiday party. Please update the Office of Human Resources **if you move or change email addresses** to make sure you are invited to these events.

## Meetings with TIAA

Individual meetings can be scheduled with representatives from TIAA to discuss matters regarding retirement contributions. If you are interested in meeting with a TIAA representative, please contact TIAA at (800) 732-8353 to schedule an appointment.

## Retiree Listing on Elon's Web Site

Retirees can choose to be listed on the online Faculty and Staff Retiree Directory. If you are interested in being listed, please complete the consent form found on page 22 of this booklet and return to the Office of Human Resources. The form can also be found online at <https://www.elon.edu/u/fa/hr/employee-resources/forms/> under Retiring/Exiting Elon.

## Supplemental Health Insurance Plan

The university is offering a supplemental health insurance plan to Medicare that is available for retirees and their spouses. If the retired Elon employee elects to participate in the program, the university will contribute \$100 towards the cost of the monthly premium for the retired employee.

Forms to enroll in the plan can be found in the packet on pages 13-17. If you have any questions about the plan, please contact Benistar directly through their toll free number which can be found in the booklet.

## Via Benefits

Simplified health coverage planning! We get it. Shopping and enrolling for health coverage can be confusing. We're here to help by turning this enormous responsibility into a simplified, delightful experience. How? By combining technology with humanity to cut through the complexity surrounding health coverage. That's why **Via Benefits** partners with Elon University to help you make informed decisions about health care coverage. Whether you're Medicare-eligible or not, Via Benefits is your health coverage ally. We provide you with compassionate support and peace of mind you deserve when it comes to understanding and enrolling in health coverage. Want to learn more or connect with a licensed benefit advisor?

Visit [discover.viabenefits.com/elon](https://discover.viabenefits.com/elon) Call 1-833-858-6020 Monday through Friday, 8:00 a.m. - 7:00 p.m. ET

**Please contact the Office of Human Resources at (336) 278-5560 if you have any questions about the services identified above.**



# COBRA

If you are not ready to enroll in Medicare and the supplemental insurance, you may continue your Elon Group Health, Dental and Vision Insurance Plans by electing COBRA (generally for up to 18 months, dependents up to 36 months).

Please review the information thoroughly as you consider enrolling in COBRA current benefit plans.

If you are interested in COBRA rates for Blue Cross Blue Shield NC/OptumRx – Delta Dental – VSP (Vision Service Plan) please see the chart below. Flores and Associates will mail the information to your home address.

Health - Monthly Rates	Plan A	Plan B	Plan C
Employee Only	\$754.94	\$1,230.63	\$400.24
Employee + Spouse	\$1,774.08	\$2,892.00	\$913.41
Employee + Children	\$1,245.66	\$2,030.55	\$687.51
Family	\$2,264.81	\$3,691.92	\$1,123.16

Dental - Monthly Rates	
Employee Only	\$49.15
Employee + Spouse	\$89.33
Employee + Children	\$121.87
Family	\$171.07

Vision - Monthly Rates	Core	Buy Up	Both
Employee Only	\$2.04	\$14.21	\$16.25
Employee + Spouse	\$2.69	\$18.76	\$21.45
Employee + Children	\$2.89	\$20.06	\$22.95
Family	\$4.60	\$32.08	\$36.68

# Supplemental Health Insurance

As you know, the cost of providing health care benefits is becoming increasingly expensive. This is especially true for retirees who have to rely on Medicare or expensive individual supplemental coverage. While Medicare coverage is a necessity for many retired people, there are limits to the protection it provides. Deductibles and co-insurance charges for medical services, hospitals, skilled nursing facilities, nursing homes, and more are not covered. These out-of-pocket expenses can be hard to pay on a retiree's fixed income.

The university offers a **Supplemental Health Insurance Plan to Medicare** for retirees who are eligible under Medicare and meet the university's eligibility criteria. The medical portion, underwritten by The Hartford, fills in the coverage gaps of Medicare Part A and Part B. The pharmacy portion, underwritten by Express Scripts, provides a prescription drug benefit.

Some of the program features include:

- Group underwriting on a guarantee issue basis (no individual underwriting)
- No pre-existing condition limitations as long as you are coming directly from another group plan or another supplemental plan. If there is a gap in coverage prior to participation in this plan, a six-month pre-existing limitation will apply.

The university will contribute \$100 per month on behalf of each retired faculty or staff member who enrolls in the program. Please note the university's contribution is for retired Elon faculty and staff only. Spouses are also eligible but would have to pay the full monthly premium cost. The contribution made by the university is solely for the purpose of guaranteeing the initial viability of the program. It will never be increased for any current or future participants of the plan, either while the plan is in force or is in transition to a different plan provided by Elon or by another as identified in the following paragraph.

Please keep in mind that this plan is not a continuation of the current Elon group health insurance plan provided to employees but as a supplement to Medicare. As the plan administrator, Elon has the discretionary authority to terminate the plan for new retirees, amend the plan, or transition to another post retirement supplemental health plan offered by the government or another private agency.

**If you have any questions regarding Supplemental Health Insurance please contact the Benistar Retiree Service Center at (800) 236-4782.**



# Supplemental Medical Insurance Part A & B

Group Retiree Insurance Plan; Through Benistar Employer Services Trust  
Summary of Coverage<sup>1</sup>; Underwritten by: Hartford Life and Accident Insurance Company

Part A Services	Medicare Pays	Plan Pays	You Pay
<b>Hospitalization<sup>2</sup>:</b> Semi-private room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,736	\$1,736	\$0
61 <sup>st</sup> through 90 <sup>th</sup> day	All but \$434 per day	\$434 per day	\$0
91 <sup>st</sup> through 150 <sup>th</sup> day (60 day Lifetime Reserve Period)	All but \$868 per day	\$868 per day	\$0
Once Lifetime Reserve days are used (or would have ended if used) additional 365 days of confinement per person per lifetime.	\$0	100%	\$0
<b>Skilled Nursing Facility Care<sup>2</sup>:</b> Semi-private room and board, skilled nursing and rehabilitative services and other services and supplies. You must meet Medicare's requirements which includes hospitalization of at least 3 days. You must enter a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21 <sup>st</sup> through 100 <sup>th</sup> day	All but \$217 per day	Up to \$217 per day	\$0
<b>Hospice Care:</b> Pain relief, symptom management and support services for terminally ill.			
As long as Physician certifies the need	All costs, but limited to costs for out-patient drug and in-patient respite care	Co-insurance charges for in-patient respite care, drugs and biologicals approved by Medicare	All other charges
<b>Blood Deductible - Hospital Confinement and Out-Patient Medical Expenses:</b> When furnished by a hospital or skilled nursing facility during a covered stay.			
First 3 pints	\$0	100%	\$0
Additional amounts	100%	\$0	\$0
Part B Services	Medicare Pays	Plan Pays	You Pay
<b>Out-Patient Medical Expenses - In or Out of the Hospital and Out-Patient Hospital Treatment:</b> such as Physician's services, In-Patient and Out-Patient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
Medicare Part B Deductible	\$0	\$283	\$0
First \$283 of Medicare-approved amounts.			
Remainder of Medicare-approved amounts.	80%	100%	\$0
Clinical Laboratory services, blood tests, urinalysis and more.	100%	\$0	\$0
Part B Excess Charges for Non-Participating Medicare providers covers the difference between the 115% Medicare-approved Part B charge.	\$0	100%	0%

# Supplemental Medical Insurance Continued

Additional Services	Medicare Pays	Plan Pays	You Pay
<b>Preventive Medical Care &amp; Cancer Screenings<sup>3</sup>:</b> Coverage for expenses incurred by a covered person for physical exams, preventive screening tests and services, cancer screenings, and any other tests or preventive measures determined to be appropriate by the attending Physician. Refer to your Medicare and You handbook for more information on Preventive services.			
<b>"Welcome to Medicare"</b> Physical Exam - within first 12 months of Part B enrollment	100%	\$0	\$0
Annual Wellness Visit	100%	\$0	\$0
Vaccinations	100%	\$0	\$0
Breast Cancer Screening - Mammogram once per year; Breast exam once every 2 years, or once per year if at high risk	100%	\$0	\$0
Colon Cancer Screening - Fecal occult blood test once per year; Colonoscopy once every 10 years, or every two years if high risk	100% for Fecal Occult Blood Test and Colonoscopy	\$0	\$0
Barium enema once every 4 years, or once every 2 years if at high risk	80% after deductible for Barium Enema	100%	\$0
Cervical Cancer Screening - Pap Smear and Pelvic exam once every 2 years, or once per year if high risk	100%	\$0	\$0
Prostate Cancer Screening - PSA Test once per year	100% for PSA Test	\$0	\$0
Digital Rectal exam once per year	80% after deductible for Digital Rectum exam	100%	\$0
Ovarian Cancer Surveillance Tests - once per year if at high risk	80% after deductible	100%	\$0
<b>Foreign Travel Emergency:</b> Medically necessary emergency care services			
Emergency services needed due to Injury or Sickness of sudden and unexpected onset during the first 60 days while traveling outside the United States	\$0	80% after \$250 Deductible (to a lifetime maximum of \$50,000)	\$250 Deductible and then 20% of expenses incurred (to a lifetime maximum of \$50,000, 100% thereafter)

<sup>1</sup> Coverage amounts valid from January 1, 2026 to December 31, 2026.

<sup>2</sup> A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

<sup>3</sup> If any of the cancer screening tests are not covered by Medicare, the plan will pay the usual and customary charges incurred.

# Medicare Part D Prescription Drug Benefits

Here is a summary of what you will pay for covered prescription drugs across the different stages of your Medicare Part D benefit. You can fill your covered prescriptions at a network retail pharmacy or through our home delivery service. For maintenance medications, you have the choice of filling prescriptions for more than a one-month supply at pharmacies with preferred cost-sharing, including CVS and select independent local pharmacies. These pharmacies may offer you lower cost-sharing than the standard cost-sharing offered by other pharmacies within our network.

<b>Deductible Stage</b>	You do not pay a yearly deductible.			
<b>Initial Coverage Stage</b>	You will pay the following until your total yearly drug costs (what you and the plan pay) reach \$2,000:			
		<b>Retail One-Month (31-day) Supply</b>	<b>Retail Three-Month (90-day) Supply</b>	<b>Home Delivery Three-Month (90-day) Supply</b>
	Tier 1: <b>Generic Drugs</b>	\$9 copayment	Preferred cost-sharing: \$18 copayment Standard cost-sharing: \$27 copayment	\$18 copayment
	Tier 2: <b>Preferred Brand Drugs</b>	\$49 copayment	Preferred cost-sharing: \$125 copayment Standard cost-sharing: \$147 copayment	\$125 copayment
	Tier 3: <b>Non-Preferred Drugs</b>	50% coinsurance	50% coinsurance	50% coinsurance
	Tier 4: <b>Specialty Drugs</b>	33% coinsurance	33% coinsurance	33% coinsurance
	<ul style="list-style-type: none"> <li>If your doctor prescribes less than a full month's supply of certain drugs, you will pay a daily cost-sharing rate based on the actual number of days of the drug that you receive.</li> <li>You may receive up to a 90-day supply of certain maintenance drugs (medications taken on a long term basis) by mail through <b>Express Scripts Pharmacy</b>. There is no charge for standard shipping. Not all drugs are available at a 90-day supply, and not all retail pharmacies offer a 90-day supply.</li> <li>If you have any questions about this coverage, please contact the Retiree Customer Service Center at 1.800.236.4782, Monday through Friday, 8:30am through 5:30pm, Eastern Time. TTY users should call 711.</li> </ul>			
<b>Catastrophic Coverage Stage</b>	If you reach the Catastrophic Coverage stage, you pay nothing for covered Part D drugs. You may have cost sharing for excluded drugs that may be covered under an enhanced benefit.			

For more information on the prescription drug benefits please contact Benistar Retiree Service Center at (800)-236-4782.

# Supplemental Health Plan Rates

Please review the information thoroughly as you consider enrolling in the Supplemental Medicare Retiree Health Plan.

Elon University has contracted with **The Hartford** for Supplemental Medical benefits and **Express Scripts** for Supplemental Pharmacy benefits.

## Supplemental Retiree Health Plan

Total Monthly Cost	
Retiree Only*	\$389.90
Spouse Only	\$489.90
Retiree + Spouse*	\$879.80

***\*Elon University contributes \$100 per month on behalf of each retiree! The cost above reflects the \$100 contribution from Elon University.***

## What You Need to Know:

- Elon University will contribute \$100 per month on behalf of each retiree, who enrolls in the program.
- When you (and/or your spouse) enroll in The Hartford medical plan you will automatically be enrolled into the Express Scripts Pharmacy Plan.
- You (and/or your spouse) cannot choose to participate in the retiree medical and pharmaceutical plan separately. In other words, you (and/or your spouse) cannot opt out of one plan and take the other.
- You (and/or your spouse) will receive only one monthly bill from Benistar.
- Please keep in mind that this plan is NOT a continuation of the current Elon Group Health Insurance Plan provided to employees, but a supplement to Medicare.
- If you have any questions regarding the Supplemental Medicare Retiree Health Plan – Please contact the Benistar Retiree Service Center at (800)-236-4782.



**Group Benefits from The Hartford****HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY**

One Hartford Plaza

Hartford, CT 06155

(A stock insurance company)



The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.

GROUP RETIREE HEALTH INSURANCE – GRIP (THE HARTFORD'S GROUP RETIREE INSURANCE PLAN®)

ENROLLMENT FORM

FOR INITIAL ENROLLMENT AND SUBSEQUENT CHANGES

Participating Employer: **ELON UNIVERSITY**Policy Number(s): **AGP-007040**

Please Print clearly in ink or type:

Retiree's First Name:	Middle:	Last:
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Street:
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City:	State:	ZIP Code:
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Phone Number: (      )	Medicare Number
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Email Address:
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Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	Social Security #
--------------------------------------------------------------------------	----------------	-------------------

Date of Retirement:	Have you enrolled in Medicare Part B? <input type="checkbox"/> Yes <input type="checkbox"/> No
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If no, when do you intend to enroll?
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**Spouse's Name (Only if enrolling):**

First:	Middle:	Last:
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Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:
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Social Security #	Medicare Number
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Date of Retirement:	Has your spouse enrolled in Medicare Part B? <input type="checkbox"/> Yes <input type="checkbox"/> No
---------------------	----------------------------------------------------------------------------------------------------------

If no, when does he/she intend to enroll?
-------------------------------------------

**To the best of your knowledge:**

1. Do you or your spouse, if enrolling, have any other health insurance including an employer health plan?

Retiree: <input type="checkbox"/> Yes <input type="checkbox"/> No	Spouse: <input type="checkbox"/> Yes <input type="checkbox"/> No
-------------------------------------------------------------------	------------------------------------------------------------------

If so, please provide the information requested below:

<u>Covered Person</u>	<u>Company Name</u>	<u>Policy Number</u>	<u>Kind of Policy</u>	<u>Effective Date</u>	<u>Expiration Date</u>

2. If the answer to question 1 is yes, do you or your spouse, if enrolling intend to replace these medical or health policies with this policy or certificate?			
Retiree: <input type="checkbox"/> Yes <input type="checkbox"/> No		Spouse: <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, for what reason are you (or your spouse, if enrolling) replacing the coverage?			
<input type="checkbox"/> Additional Benefits <input type="checkbox"/> Fewer benefits and lower premiums <input type="checkbox"/> Integration with Medicare <input type="checkbox"/> No change in benefits, but lower premiums <input type="checkbox"/> Other (please specify):			
3. Are you covered by Medicaid?			
Retiree: <input type="checkbox"/> Yes <input type="checkbox"/> No		Spouse: <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Check Desired Coverage</b>			
	<b>Effective Date</b>	<b>Plan 1</b>	<b>n/a</b>
<b>Retiree:</b>		<input type="checkbox"/>	<input type="checkbox"/>
<b>Spouse:</b>		<input type="checkbox"/>	<input type="checkbox"/>

Complete the form answering all questions. Please be sure to date and sign the form and return to:

**Benistar Administrative Services, Inc. (BASI)**  
**10 Tower Lane, First Floor**  
**Avon, CT 06001**

<b>Confirmation</b>	
I acknowledge that I have been given the opportunity to enroll in the insurance offered by the Policyholder. I understand and agree that if I decline insurance now, I may not be able to enroll in the future.	
I understand and agree that insurance will go into effect and remain in effect only in accordance with the provisions, terms and conditions of the insurance policy. I understand and agree that only the insurance policy issued to the Policyholder can fully describe the provisions, terms, conditions, limitations and exclusions of my insurance. In the event of any difference between the enrollment form and the insurance policy, I agree to be bound by the insurance policy.	
<b>Fraud Notice(s)</b>	
<b>For Residents of Florida:</b>	
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.	
<b>For Residents of Louisiana:</b>	
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.	
<b>For Residents of Maryland:</b>	
Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.	
<b>For Residents of New York:</b>	
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.	
<b>For Residents of Virginia:</b>	
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits	
<b>Retiree Signature:</b>	<b>Date:</b>
<b>Spouse Signature (if enrolling):</b>	<b>Date:</b>

# Supplemental Health Enrollment Form

# MEDICARE PRESCRIPTION DRUG PLAN INDIVIDUAL ENROLLMENT FORM

## ELON UNIVERSITY SPONSORED GROUP PLAN

**To enroll in Express Scripts Medicare® (PDP) please provide the following information:**

Desired Effective Date: \_\_\_\_\_

LAST Name:		FIRST Name:		MIDDLE Initial:		Mr	Mrs.	Ms.
Birth Date: ( ____/____/____ ) ( M M / D D / Y Y Y Y )		Sex: M      F		Home Phone Number: (      )				
Permanent Residence Street Address:								
City:				State:		ZIP Code:		
<b>Mailing Address</b> (only if different from your Permanent Residence Address):								
Street Address:				City:		State:		ZIP Code:
<b>Emergency Contact:</b> [Optional]								
<b>Phone Number:</b> [Optional] _____ <b>Relationship to You</b> [Optional] _____								
<b>E-mail Address:</b> [Optional]								

### Please Provide Your Medicare Insurance Information

<p>Please take out your Medicare Card to complete this section.</p> <ul style="list-style-type: none"> <li>Please fill in these blanks so they match your red, white and blue Medicare card.</li> </ul> <p>- OR -</p> <ul style="list-style-type: none"> <li>Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.</li> </ul>	<p>Name: _____</p> <p>Medicare Number          _____ - _____ - _____</p> <p><u>OR</u> Medicare Claim Number          ____ - ____ - ____ - _____ - _____</p>
<p>You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.</p>	<p>Is Entitled To _____ Effective Date _____</p> <p><b>HOSPITAL (Part A)</b>  <b>MEDICAL (Part B)</b> _____</p>

2022 BXMA

(10/21)

Email completed enrollment form to **memelig@bensitar.com** or mail to **Benistar Admin Services**  
**10 Tower Lane, Suite 100**  
**Avon, CT 06001**

# Supplemental Health Enrollment Form

## Please read and answer these important questions:

Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State Pharmaceutical Assistance Programs.

Will you have other prescription drug coverage in addition to your former Employer's retiree plan? Yes No  
If "yes", please list your other coverage and your identification (ID) number(s) for this coverage.

Name of other coverage:

ID # for this coverage:

Group # for this coverage:

## Important Information About Your Medicare Part D Prescription Drug Plan

**Express Scripts Medicare®** (PDP), is offered by Medco Containment Life Insurance Company or Medco Containment Insurance Company of New York (for employer plans domiciled in New York). (When this document says "we," "us" or "our," it means Medco Containment Life Insurance Company or Medco Containment Insurance Company of New York (for employer plans domiciled in New York). When it says "plan" or "our plan," it means Express Scripts Medicare.) This coverage is Medicare Part D coverage and is in addition to your coverage under Medicare Parts A and B. You must keep your Medicare Parts A and/or B coverage in order to qualify for this plan. You must inform your former employer of any other prescription drug coverage you may have.

### Enrollment Requirements

You can be in only one Medicare prescription drug plan at a time. If you are currently in a Medicare prescription drug plan, a Medicare Advantage Plan with prescription drug coverage, or an individual Medicare Advantage Plan, your enrollment in Express Scripts Medicare may end that enrollment.

You must live within the 50 U.S. states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands or American Samoa, and be a U.S. citizen or lawfully present in the United States to participate in this plan. It is your responsibility to inform your former employer of any address changes.

You can join a new Medicare prescription drug plan or Medicare health plan from October 15 to December 7. Except in special cases, you cannot join a new plan at any other time of the year. If you leave this plan and don't have or get other Medicare prescription drug coverage or creditable coverage (as good as Medicare's), you may be required to pay a late enrollment penalty (LEP) if you go 63 days or more without Medicare Part D coverage or other creditable prescription drug coverage.

Some people may have to pay an extra premium amount because of their yearly income. If you have to pay an extra amount, the Social Security Administration – not your Medicare plan – will send you a letter telling you what that extra amount will be and how to pay it. If you have any questions about this extra amount, contact the Social Security Administration at 1.800.772.1213. TTY users call 1.800.325.0778.

Medicare beneficiaries with low or limited income and resources may qualify for Extra Help. If you qualify, your Medicare prescription drug plan costs will be less. Once you are enrolled in this drug plan, Medicare will tell the plan how much assistance you will receive and Express Scripts will send you information on the amount you will pay. If you are not currently receiving Extra Help, you can contact 1.800.MEDICARE (1.800.633.4227) to see if you might qualify. TTY users call 1.877.486.2048.

Once you are a member of this plan, you have the right to file a grievance or appeal plan decisions about payment or services if you disagree. Read your *Evidence of Coverage* to know which rules you must follow to receive coverage with this Medicare prescription drug plan.

This information is not a complete description of benefits. Contact Express Scripts Medicare for more information. Limitations, copayments and restrictions may apply. Benefits, premium (if applicable) and/or copayments/coinsurance may change on January 1 of each year. The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

# Supplemental Health Enrollment Form

## IMPORTANT: Read and Sign Below:

- **Release of Information:** By joining this Medicare Advantage Prescription Drug Plan/Prescription Drug Plan, I acknowledge that the plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Express Scripts will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan. I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S.border.
- I understand that I can be enrolled in only one MA or Part D plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA or Part D plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
  - 1) This person is authorized under State law to complete this enrollment, and
  - 2) Documentation of this authority is available upon request by Medicare.

<b>Signature:</b>	<b>Today's Date:</b>
If you are the authorized representative, you must sign above and provide the following information:	
<b>Name:</b>	<b>Address:</b>
<b>Phone Number:</b>	<b>Relationship to Enrollee:</b>

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**GROUP LIFE CONVERSION APPLICATION**  
**Reliance Standard Life Insurance Company**

This form is to be used only when an eligible person desires to convert his/her Group Life insurance to an Individual policy. This form must be completed in full and submitted to the Company within 31 days following the effective date of termination of insurance. The top portion of this form is to be completed by the policyholder, the lower portion by the applicant. You may wish to refer to your policy's Schedule of Benefits page to complete some of the questions on this application.

Questions? Call Protective Life at 800-866-9933.

**When all areas are complete, mail to: Insurance Services, Division of Protective Life Insurance Company, Post Office Box 12687, Birmingham, AL 35202-6687, Fax: (205) 268-3402, Email: [service@protective.com](mailto:service@protective.com).**

**TO BE COMPLETED BY POLICYHOLDER**

Name and Address of Group Policyholder and, if applicable, Division Name: \_\_\_\_\_  
Policy No.: \_\_\_\_\_ Policy Eff. Date: \_\_\_\_\_  
Insured's Full Name: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Annual Salary/Earnings: \$ \_\_\_\_\_  
Social Security No.: \_\_\_\_\_ Date Employment Began: \_\_\_\_\_  
Occupation/Job Title: \_\_\_\_\_ Date Last Worked: \_\_\_\_\_  
Scheduled Work Hours: \_\_\_\_\_/week Insured's Premium Paid To: \_\_\_\_\_  
Insured's Effective Date: \_\_\_\_\_ Insurance Class: \_\_\_\_\_ Insurance Amount: Basic \$ \_\_\_\_\_ Supp \$ \_\_\_\_\_  
Reason Insured Stopped Work (specify): \_\_\_\_\_ Dependent Insurance Amounts: \_\_\_\_\_  
Conversion Rights Exercised Due To (check applicable response): Spouse: \_\_\_\_\_  
\_\_\_\_\_ (1) Employee Terminated Employment On: \_\_\_\_\_ Children: \_\_\_\_\_  
\_\_\_\_\_ (2) Group Policy Terminated On: \_\_\_\_\_  
\_\_\_\_\_ (3) Disability of the Insured On: \_\_\_\_\_ Has A Waiver of Premium Claim Been Submitted to RSL? Yes \_\_\_ No \_\_\_  
If No, Please Explain: \_\_\_\_\_  
\_\_\_\_\_ (4) Other, Please Explain: \_\_\_\_\_

I have reviewed the information set forth, and represent that to the best of my knowledge and belief it is true and correct.

Signature Of Policyholder's Authorized Representative \_\_\_\_\_ Title \_\_\_\_\_ Date Signed \_\_\_\_\_

Phone Number of Representative \_\_\_\_\_ Federal Employer Identification Number \_\_\_\_\_

**TO BE COMPLETED BY APPLICANT**

I would like to convert \$ \_\_\_\_\_ of my group life insurance coverage that was in-force prior to the termination date.  
I desire to convert \$ \_\_\_\_\_ of insurance for my dependent spouse and \$ \_\_\_\_\_ of insurance for my dependent child(ren) to an individual policy, if applicable.

Desired Mode of Premium Payment \_\_\_\_\_ Quarterly \_\_\_\_\_ Semi-Annually \_\_\_\_\_ Annually

**Beneficiary Designation**

Upon the death of the insured, the proceeds of the policy to which this application is attached shall be paid as follows:

**Primary Beneficiary(s)**

Name _____	Address _____	Relationship _____	Percentage _____
Name _____	Address _____	Relationship _____	Percentage _____

**Contingent Beneficiary(s)**

Name _____	Address _____	Relationship _____	Percentage _____
Name _____	Address _____	Relationship _____	Percentage _____

If more than one primary beneficiary is named and no percentage is indicated, payment will be in equal shares to the surviving primary beneficiary(s). If there are no surviving primary beneficiary(s), the proceeds will be paid to the contingent beneficiary(s). If more than one contingent beneficiary is named and no percentage is indicated, payment will be in equal shares to the surviving contingent beneficiary(s). If there are no surviving contingent beneficiary(s), the proceeds will be paid to the executors, administrators, or assigns of the owner.

Applicant's Address \_\_\_\_\_  
City, State, Zip Code \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

I have reviewed the information set forth above and represent that to the best of my knowledge and belief it is true and correct.

Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

**Reliance Standard Life Insurance Company**

**GL & VG Conversion Rates**

(These rates may change without prior notice to you)

**Whole Life Insurance Policy**

**Table of Current Annual Premium Rates**

Per \$1,000.00 of Face Value

Issue Age	Rate	Issue Age	Rate	Issue Age	Rate
0 - 15	\$20.00	48	\$44.85	81	\$351.11
16	\$21.25	49	\$46.75	82	\$377.34
17	\$21.67	50	\$49.08	83	\$405.32
18	\$21.87	51	\$51.74	84	\$435.22
19	\$22.20	52	\$54.50	85	\$466.82
20	\$22.30	53	\$57.75	86	\$499.98
21	\$22.35	54	\$61.56	87	\$534.31
22	\$22.48	55	\$65.09	88	\$569.45
23	\$22.57	56	\$69.00	89	\$608.70
24	\$22.63	57	\$73.29	90	\$644.27
25	\$22.70	58	\$77.97	91	\$680.55
26	\$22.79	59	\$82.14	92	\$715.39
27	\$22.89	60	\$87.60	93	\$750.11
28	\$23.17	61	\$93.53	94	\$781.68
29	\$23.23	62	\$99.94	95	\$810.35
30	\$23.75	63	\$106.22	96	\$829.35
31	\$24.50	64	\$113.23	97	\$829.35
32	\$24.55	65	\$121.68	98	\$829.35
33	\$25.25	66	\$130.19	99	\$829.35
34	\$25.81	67	\$139.50	100	\$829.35
35	\$26.50	68	\$149.68		
36	\$27.25	69	\$156.00		
37	\$28.00	70	\$156.06		
38	\$28.86	71	\$167.08		
39	\$30.00	72	\$179.28		
40	\$31.52	73	\$192.12		
41	\$32.25	74	\$206.37		
42	\$33.75	75	\$222.60		
43	\$35.32	76	\$240.06		
44	\$36.75	77	\$258.80		
45	\$38.50	78	\$279.82		
46	\$40.50	79	\$302.24		
47	\$42.25	80	\$325.90		

**Term Life Insurance Portability Request**

This form is to be used only when a person desires and is eligible to port Term Life Insurance. This form must be completed in full and submitted to The Company within 31 days following the date of termination. **Important: Basic Life Insurance is applicable for GL and VG coverages. Supplement Life Insurance is only applicable for GL coverage.** SEND TO:  
 AmWINS Group Benefits, LLC, P.O. Box 152501, Irving, TX 75015-2501. AmWINS Email: irvcustomerservice@amwins.com.  
 Fax number: 1-469-417-1675.

**VERIFICATION OF INSURED PERSON'S ELIGIBILITY TO PORTATE TERM LIFE INSURANCE**

<u>To Be Completed By Policyholder/Participating Unit</u>			
1. Insured Person's full name _____ (Please Print)		2. Soc. Sec. Number _____ Male <input type="checkbox"/> Female <input type="checkbox"/>	
3. Name of Policyholder/Participating Unit _____		4. Policyholder/Participating Unit No.: _____ <small>* If you are porting 2 policies, please complete 2 Portability Applications</small>	
5. Branch or Location (if different from 3.) _____			
6. Date Employed: _____ Salary: _____ Date Last Salary Change: _____ Class: _____			
7. Effective Date of Coverage: Employee: _____ Spouse, if any: _____ Children, if any: _____			
8. Occupation/Job Title _____ 9. Date Person Last Worked _____			
10. Date Employment Terminated (if different from 9.) _____			
11. If (9) and (10) differ, please explain _____			
12. Was the Insured's Termination due to retirement? Yes <input type="checkbox"/> No <input type="checkbox"/>			
13. Amount of Term Life Insurance (including the amount of any AD&D rider coverage, if applicable) in force under the Policy on date of termination:			
<b>Basic Life Insurance applies to GL &amp; VG coverages / Supplemental Life Insurance applies to GL coverage only</b>			
Basic Life Insurance:	Employee \$ _____	Spouse, if any \$ _____	Children, if any \$ _____
Supp. Life Insurance:	Employee \$ _____	Spouse, if any \$ _____	Children, if any \$ _____
AD&D Life Insurance:	Employee \$ _____	Spouse, if any \$ _____	Children, if any \$ _____
14. Verified by _____ (Signed by authorized individual)      Date      Phone Number      Email Address			

<u>To Be Completed By Applicant</u>			
Name _____		Spouse's Name _____	
Address _____ (Street)      (City)      (State)      (Zip)			
Date of Birth: Employee: _____ Spouse, if any _____ Children, if any _____			
Please indicate amount of coverage desired below (must be equal to or less than the amount in force). Your election(s) may not exceed any coverage limits stated in your policy (typically \$500,000 per individual). Please contact your former employer if you are unsure of the maximum amount of coverage you are eligible to continue.			
<b>Basic Life Insurance applies to GL &amp; VG coverages / Supplemental Life Insurance applies to GL coverage only</b>			
Basic Life Insurance:	Employee \$ _____	Spouse, if any \$ _____	Children, if any \$ _____
Supp. Life Insurance:	Employee \$ _____	Spouse, if any \$ _____	Children, if any \$ _____
AD&D Life Insurance:	Employee \$ _____	Spouse, if any \$ _____	Children, if any \$ _____
Beneficiary:			
Full Name(s)	Relationship	Percent of Proceeds	SSN
_____	_____	_____	_____
_____	_____	_____	_____
Signature of Applicant	Email Address	Phone Number	Date Signed

## **GL & VG Standard Portability Rates Effective July 1, 2014**

### **Insured and Spouse Rates**

<b>Attained</b>	<b>Monthly Rates per \$1000</b>		<b>Quarterly Rates per \$10,000</b>	
<b>Age Band</b>	<b>Term Life</b>	<b>AD&amp;D</b>	<b>Term Life</b>	<b>AD&amp;D</b>
<b>&lt; 30</b>	\$0.21	\$0.059	\$6.38	\$1.76
<b>30-34</b>	\$0.27	\$0.049	\$8.20	\$1.47
<b>35-39</b>	\$0.33	\$0.046	\$10.02	\$1.39
<b>40-44</b>	\$0.51	\$0.046	\$15.43	\$1.39
<b>45-49</b>	\$0.84	\$0.048	\$25.33	\$1.43
<b>50-54</b>	\$1.42	\$0.050	\$42.50	\$1.51
<b>55-59</b>	\$2.35	\$0.055	\$70.42	\$1.64
<b>60-64</b>	\$3.10	\$0.059	\$92.86	\$1.76
<b>65-69</b>	\$4.45	\$0.063	\$133.48	\$1.89
<b>70+</b>	\$9.25	\$0.069	\$277.48	\$2.06


### **Dependent Child Rates**

<b>Coverage Amount</b>	<b>Quarterly Rate</b>
\$1,000 ages 14 days to six months and \$2,000 for six months to 20 years	\$2.60
\$1,000 ages 14 days to six months and \$2,000 for six months to 20 years; Full-time students under 26 years	\$2.73
\$1,000 ages 14 days to six months and \$2,500 for six months to 20 years; Full-time students under 26 years	\$3.07
\$1,000 ages 14 days to six months and \$5,000 for six months to 20 years; Full-time students under 26 years	\$4.58
\$1,000 ages 14 days to six months and \$7,500 for six months to 20 years;	\$6.13
\$1,000 ages 14 days to six months and \$10,000 for six months to 20 years; Full-time students under 26 years	\$7.69
\$1,000 ages 14 days to six months and \$20,000 for six months to 20 years; Full-time students under 26 years	\$13.89

Customer Care is available Monday through Friday from 8 a.m. to 7 p.m. (Eastern).  
Call **800-268-4887** if you need assistance.

# Online Retiree Directory

I, \_\_\_\_\_ give permission for only the personal information I have identified below to be listed on the Elon  
(print name)  
University web site.

 Please PRINT or TYPE the following information, and either submit the form electronically to [hr@elon.edu](mailto:hr@elon.edu) or send it to the Office of Human Resources, 2070 Campus Box, Elon, NC 27244. Once it has been received, the information will be added to the

Elon University web site.

Please type or print **only** the information you would like to appear on the web site and sign below.

☐ Mr.      ☐ Ms.      ☐ Mrs.      ☐ Miss      Dr.

First Name \_\_\_\_\_

Middle Name \_\_\_\_\_

Last Name \_\_\_\_\_

Suffix \_\_\_\_\_

## Mailing Address

Street or PO Box \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone # (include area code) \_\_\_\_\_

Email Address \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date/Time Field

This form can be found online at [www.elon.edu/e-web/bft/hr/retirementPlan.xhtml](http://www.elon.edu/e-web/bft/hr/retirementPlan.xhtml)



# Contact Information



	Phone Number	Website/Email
<b>Benistar</b>		
Customer Service Department – Amber Willis	1-800-236-4782	-
The Hartford – Name: Insured's Name / Member ID: Medicare Beneficiary Identifier / Group Policy Number: AGP-007040		
Express Scripts – Claim Adjudication Information: Express Scripts PDP / RxBin: 00358 / RxPCN: MD / RxGrp: BXMA / Member ID / Name / Member Date of Birth		
Eligibility Department – Jane Moticka	1-800-236-4782 ext. 5217	<a href="mailto:jmoticka@benistar.com">jmoticka@benistar.com</a>
<b>Via Benefits</b>		
Via Benefits – Licensed Benefits Advisors	1-833-858-6020	<a href="https://discover.viabenefits.com/elon">discover.viabenefits.com/elon</a>
<b>Reliance Standard</b>		
Note: Only 31 days to elect coverage	1-800-351-7500	<a href="https://www.reliancematrix.com">www.reliancematrix.com</a>
<b>Wellfleet</b>		
Contact if you wish to keep your Wellfleet benefits.	1-855-664-5838	<a href="https://www.wellfleetworkplace.com/register">www.wellfleetworkplace.com/register</a>
<b>Aflac</b>		
Brandon Harvey – Contact if you wish to keep your Aflac benefits.	336-991-4590	<a href="mailto:brandon_harvey@us.aflac.com">brandon_harvey@us.aflac.com</a>
<b>TIAA</b>		
Retirement Plan	1-800-732-8353	<a href="https://tiaa.org/schedulenow">tiaa.org/schedulenow</a>
<b>Social Security Administration</b>		
Social Security Administration	Greensboro office – 877-319-3075 Reidsville office – 866-748-2091 Durham office – 888-759-3908 National office – 800-772-1213	<a href="https://ssa.gov">ssa.gov</a>
<b>Medicare</b>		
Medicare	1-800-633-4227	<a href="https://medicare.gov">medicare.gov</a>
<b>Elon University</b>		
Office of Human Resources	1-336-278-5560	<a href="https://elon.edu/u/fa/hr/">elon.edu/u/fa/hr/</a>



**2026 Elon University Retiree Benefits Guide**