ELON UNIVERSITY

2024 Retiree Benefits Guide

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Pre-Retirement Resources

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

TIAA Webinars - Attend a live webinar or view a recorded webinar from TIAA on retirement. Webinar topics include:

Social Security Basics

Retiring in the New Normal

Understanding Medicare

Visit www.tiaa.org/webinars to view the webinars available to you.

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/benefits/retirement/learn.html. 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
	Schedule an appointment with the TIAA representative regarding your retirement plan
	Visit medicare.gov/basics/get-started-with-medicare 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 will be paid out in the 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.
- Even though faculty are paid through August, the retirement date is the end of May. 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 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

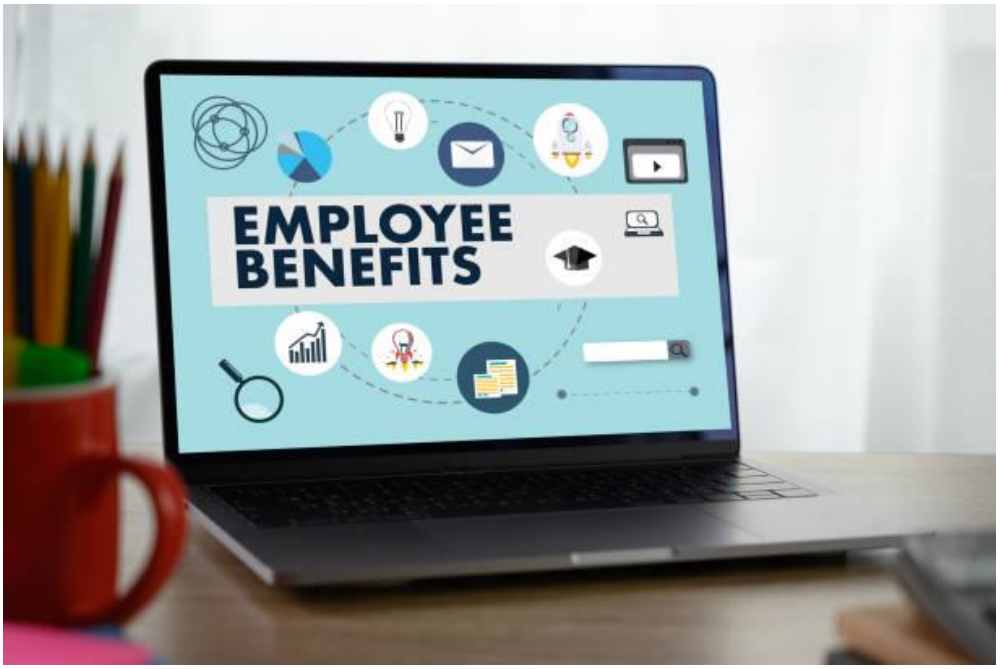
Retirees can choose to be listed on the online Faculty and Staff Retiree Directory. If you are interested in being listed, please complete the consent form found on page 22 of this booklet and return to the Office of Human Resources. The form can also be found online at www.elon.edu/hr under the retiree section.

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.

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 – 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	$664.37	$1,217.46	$427.32
Employee + Spouse	$1,561.22	$2,861.04	$1,004.20
Employee + Children	$1,096.20	$2,008.82	$705.06
Family	$1,993.07	$3,652.40	$1,281.97

Dental - Monthly Rates	
Employee Only	$46.76
Employee + Spouse	$84.99
Employee + Children	$115.94
Family	$162.74

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[1]; Underwritten by: Hartford Life and Accident Insurance Company

Part A Services	Medicare Pays	Plan Pays	You Pay
Hospitalization[2]: Semi-private room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632	$0
61st through 90th day	All but $408 per day	$408 per day	$0
91st through 150th day (60 day Lifetime Reserve Period)	All but $816 per day	$816 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
Skilled Nursing Facility Care[2]: 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
21st through 100th day	All but $204 per day	Up to $204 per day	$0
Hospice Care: 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
Blood Deductible - Hospital Confinement and Out-Patient Medical Expenses: 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**
Out-Patient Medical Expenses - In or Out of the Hospital and Out-Patient Hospital Treatment: 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 First $240 of Medicare-approved amounts.	$0	$240	$0
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
Preventive Medical Care & Cancer Screenings[3]: 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.			
"Welcome to Medicare" 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
Foreign Travel Emergency: 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)

[1] Coverage amounts valid from January 1, 2024 to December 31, 2024.

[2] 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.

[3] 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.

<table>
<tr><td>Deductible Stage</td><td>You do not pay a yearly deductible.</td></tr>
<tr><td>Initial Coverage Stage</td><td>You will pay the following until your total yearly drug costs (what you and the plan pay) reach $5,030:
<table>
<tr><th></th><th>Retail
One-Month
(31-day) Supply</th><th>Retail
Three-Month
(90-day) Supply</th><th>Home Delivery
Three-Month
(90-day) Supply</th></tr>
<tr><td>Tier 1: Generic Drugs</td><td>$9 copayment</td><td>Preferred cost-sharing:
$18 copayment
Standard cost-sharing:
$27 copayment</td><td>$18 copayment</td></tr>
<tr><td>Tier 2: Preferred Brand Drugs</td><td>$49 copayment</td><td>Preferred cost-sharing:
$125 copayment
Standard cost-sharing:
$147 copayment</td><td>$125 copayment</td></tr>
<tr><td>Tier 3: Non-Preferred Drugs</td><td>50% coinsurance</td><td>50% coinsurance</td><td>50% coinsurance</td></tr>
<tr><td>Tier 4: Specialty Drugs</td><td>33% coinsurance</td><td>33% coinsurance</td><td>33% coinsurance</td></tr>
</table>

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.
You may receive up to a 90-day supply of certain maintenance drugs (medications taken on a long term basis) by mail through Express Scripts Pharmacy. 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.
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.
</td></tr>
<tr><td>Coverage Gap Stage</td><td>No Coverage Gap; Member copays above apply</td></tr>
<tr><td>Catastrophic Coverage Stage</td><td>After your yearly out-of-pocket drug costs reach $8,000, you will pay $0.</td></tr>
</table>

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*	$325.96
Spouse Only	$425.96
Retiree + Spouse*	$751.92

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:
Street:		
City:	State:	ZIP Code:
Phone Number: ( )	Medicare Number	
Email Address:		
Gender: ☐ Male ☐ Female	Date of Birth:	Social Security #
Date of Retirement:	Have you enrolled in Medicare Part B? ☐ Yes ☐ No	
If no, when do you intend to enroll?		

Spouse's Name (Only if enrolling):

First:	Middle:	Last:
Gender: ☐ Male ☐ Female	Date of Birth:	
Social Security #	Medicare Number	
Date of Retirement:	Has your spouse enrolled in Medicare Part B? ☐ Yes ☐ 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: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

If so, please provide the information requested below:

Covered Person	Company Name	Policy Number	Kind of Policy	Effective Date	Expiration Date

Form PA-9627

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: ☐ Yes ☐ No	Spouse: ☐ Yes ☐ No

If yes, for what reason are you (or your spouse, if enrolling) replacing the coverage?

☐ Additional Benefits ☐ Fewer benefits and lower premiums
☐ Integration with Medicare ☐ No change in benefits, but lower premiums
☐ Other (please specify):

3. Are you covered by Medicaid?

Retiree: ☐ Yes ☐ No	Spouse: ☐ Yes ☐ No

Check Desired Coverage

	Effective Date	Plan 1	n/a
Retiree:		☐	☐
Spouse:		☐	☐

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

Confirmation

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.

Fraud Notice(s)

For Residents of Florida:

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.

For Residents of Louisiana:

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.

For Residents of Maryland:

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.

For Residents of New York:

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.

For Residents of Virginia:

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

Retiree Signature:	Date:
Spouse Signature (if enrolling):	**Date:**

Form PA-9627

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:	
Mailing Address (only if different from your Permanent Residence Address): Street Address:	City:	State:	ZIP Code:
Emergency Contact: [Optional]			
Phone Number: [Optional]_____	**Relationship to You** [Optional] _____		
E-mail Address: [Optional]			

Please Provide Your Medicare Insurance Information

Please take out your Medicare Card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card.

- OR -

- Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.

You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.

Name:

Medicare Number
_____-_____- _____

OR Medicare Claim Number
— — — -_____-_____- ____

Is Entitled To	Effective Date
HOSPITAL (Part A)	
MEDICAL (Part B)	_____

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.

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

CRP2101_007155.1

Life Insurance Conversion Checklist

Use the checklist below to guide you through the Life Conversion Quote and Application process:

Request For Quote – Section A. Employer / Group Administrator:

- Please note, the Employee must apply for Life Conversion within 31 days from the date of their loss of coverage. You must notify the Employee of their Conversion rights immediately following their loss of coverage. If their application is received after 31 days, Life Conversion coverage may be denied.
- Complete Section A, sign and date the Request for Quote form to confirm member eligibility information.
- Forward the completed form and this checklist to the Employee immediately following their loss of coverage.
- Once you've confirmed all information in Section A, The Lincoln National Life Insurance Company will work directly with the Employee / Proposed Insured regarding their Life Conversion application process.

Request For Quote – Section B. Employee:

- Please note, you have 31 days from the date of your loss of coverage to apply for an Individual Life Conversion Policy. If your application is received in our office after 31 days, Life Conversion may be denied. No policy will be issued and no benefit will be payable until all information, including premium is received.
- Call 1-800-423-2765 or email your Request for Quote form to ClientServices@LFG.com to receive an Individual Life Insurance Conversion Quote – you are converting from a Group Policy to an Individual Policy and premiums are subject to change.
- If you choose to accept the Life Conversion quote for Individual Life Insurance, you will be sent a copy of the quoted illustration for your review and an application to sign and return with your initial payment of the insurance premium.
- Once you have received these items, please continue on to the following instructions to complete the application process.

Application For Conversion of Group Life Insurance – Section A. Employee / Member:

To complete the application process, the following items must be returned to The Lincoln National Life Insurance Company. These items must be returned within 31 days from the date of your loss of coverage. No policy will be issued and no benefit will be payable until all information, including premium is received.

- ❑ **Request for Quote Form**
- ❑ **Application for Conversion of Group Life Insurance for each Proposed Insured (Employee, Spouse and Children)**
- ❑ **Life Insurance Illustration – you will need to sign the Signature Page of the Illustration for each Proposed Insured (Employee, Spouse and Children)**
- ❑ **Electronic Funds Transfer (EFT) Authorization (if electing to pay Monthly)**
- ❑ **Payment for the Initial Premium – based upon the quoted premium in the Life Insurance Illustration.**
- ❑ **Mail to:**

  The Lincoln National Life Insurance Company
  PO Box 0821
  Carol Stream, IL 60132-0821

Please allow approximately 60 days to finalize issuance of your Individual Life Conversion Policy. If you should need any assistance in the meantime, please contact our Client Services Department at 1-800-423-2765.

Lincoln Financial Group℠

The Lincoln National Life Insurance Company, PO Box 21008, Greensboro, NC 27420-1008
(hereinafter referred to as "the Company")

Please call 800-423-2765 for a quote or email this form to ClientServices@LFG.com.

Mail this completed form and premium payment to:
The Lincoln National Life Insurance Company
PO Box 0821, Carol Stream, IL 60132-0821

REQUEST FOR QUOTE - LINCOLN GROUP CONVERSION

A. EMPLOYER/GROUP ADMINISTRATOR: Please note, the Employee must complete the Request for Quote/Application for Conversion within 31 days from the date their Loss of Coverage.

1. Group Policy Name	Group ID	Policy Number

Covered Employee / Member Information:

2. Name *(First, MI, Last)*		3. Date of Birth *(mm/dd/yy)*
4. Date of Hire or Enrollment	5. Date Employee Insurance Terminated	6. Date Employment Terminated
7. Amount of Lost Coverage: Amount $_____	8. Date Employee Last Worked:	

9. Reason for Loss of Coverage: ☐ Retirement ☐ Disabled ☐ Employment Terminated ☐ Policy Termination ☐ Age Reduction ☐ Other, please explain: _____

Covered Spouse Information:

10. Amount of Lost Coverage for Spouse $_____

Covered Dependent Information:

11. Amount of Lost Coverage for Dependent $_____

I, the Administrator of the Group Policy, declare that the information provided above is complete and true to the best of my knowledge.

Administrator Name (Please Print)	Administrator Phone Number *(include area code)*
Administrator Email Address	

_____ _____

Signature of Employer / Group Administrator **Date**

B. EMPLOYEE/MEMBER: Please note, you must complete the Application for Conversion within 31 days from the date your Employment/Membership terminated or you had a loss of coverage. No policy will be issued and no benefit will be payable until all information, including premium is received. Please call 800-423-2765 for a Life Conversion quote (have this form available when calling) or email us at ClientServices@LFG.com. If you are interested in the proposed Life Conversion Quote, you will be sent a proposal document and Application for Conversion form to proceed with the Life Conversion Application Process.

Proposed Insured Information:

Employee Name	Employee SSN	Employee Cigarette Use ☐Yes ☐No
Employee Address		

	First Name	M.I.	Last Name	SSN	Gender	Birth Date	Cigarette Use
SPOUSE:					☐M ☐F		☐Yes ☐No
CHILDREN:					☐M ☐F		☐Yes ☐No
					☐M ☐F		☐Yes ☐No
					☐M ☐F		☐Yes ☐No

Lincoln Financial Group®

The Lincoln National Life Insurance Company, PO Box 21008, Greensboro, NC 27420-1008
(hereinafter referred to as "the Company")

Mail to:
The Lincoln National Life Insurance Company
PO Box 0821, Carol Stream, IL 60132-0821

APPLICATION FOR CONVERSION OF GROUP LIFE INSURANCE

A. APPLICANT/PROPOSED INSURED: Please call 800-423-2765 for a Life Conversion Quote. You must complete the Application for Conversion within 31 days from the date your group insurance terminated. Please note, eligibility will NOT be confirmed until the completed and signed application is received by the Company.

1. a. Group Policy Name	b. Group ID	c. Group Policy Number

Proposed Insured Information:

2. Name *(First, MI, Last)*	
3. Date of Birth *(mm/dd/yy)*	4. Social Security Number
5. Address *(Street, City, State, ZIP)*	
6. Phone Number *(include area code)*	7. ☐ Male ☐ Female
8. Has the Proposed Insured become eligible for any other Group Insurance since the date the life insurance terminated? ☐ Yes ☐ No If "Yes," for how much? _____	

Coverage Information: *(As available per product. After calling for a quote, you will receive an illustration that will assist you with completing these questions.)*

9. Plan of Insurance _____
10. Amount of Insurance *(Specified Amount, if UL or VUL)* $ _____
11. Have you smoked any cigarettes in the past 12 months? ☐ Yes ☐ No
12. Premium Mode (check one) a. ☐ Annual b. ☐ Semi-Annual c. ☐ Quarterly d. ☐ Monthly (Bank draft required for this option, please complete the attached EFT form.)
13. a. Death Benefit Option ☐ Level ☐ _____ (Not available with all products, see product specifications for details)
b. Death Benefit Qualification Test (DBQT) - For IRS purposes, premiums will be tested using: ☐ GPT ☐ CVAT **The DBQT cannot be changed after issue unless the terms of the policy require a change.**
14. Additional Benefits and Riders *(If applicable)*: ☐ Accelerated Benefit Rider ☐ Other Benefits and Riders *(not listed above)*. (Please provide full details: e.g. coverage amounts/percentages/etc.):

Beneficiary Information: *(If naming more than one Primary or Contingent Beneficiary, please attach a separate sheet of paper.)*

15. Primary Beneficiary Name	a. Relationship	b. Social Security Number
16. Contingent Beneficiary Name	a. Relationship	b. Social Security Number

Proposed Owner Information: **(***Complete this Section if the Proposed Insured is not the Owner.)*

17. Full Name of Owner	18. Relationship to Proposed Insured
19. Address of Owner *(Street, City, State, ZIP)*	20. Owner SSN or TIN

B. SUITABILITY *(Complete only if applying for Variable Life Insurance and submit allocation form(s) with this Application.)*

1. Have you, the Proposed Insured(s) and the Owner, if other than the Proposed Insured(s), received a current Prospectus for the policy applied for and have you had sufficient time to review it?	☐ Y ☐ N
2. Do you understand that the amount and duration of the death benefit may increase or decrease depending on the investment performance of funds in the Separate Account?	☐ Y ☐ N
3. Do you understand that the cash values may increase or decrease depending on the investment performance of the funds held in the Separate Account?	☐ Y ☐ N
4. With this in mind, do you believe that the policy applied for is in accord with your insurance objective and your anticipated financial needs?	☐ Y ☐ N

CASH VALUES MAY INCREASE OR DECREASE IN ACCORDANCE WITH THE EXPERIENCE OF THE SEPARATE ACCOUNT. THE DEATH BENEFIT MAY BE VARIABLE OR FIXED UNDER SPECIFIED CONDITIONS.

SERVICE OFFICE ENDORSEMENTS *(For Company Use Only. We will attach additional documentation as needed.)*

AGREEMENT AND ACKNOWLEDGEMENT

I, the Owner, certify my TIN or SSN as provided by me is correct. I also certify that I am not subject to backup withholding.

Each of the Undersigned declares that:

1. This Application consists of: a) Application for Conversion of Group Life Insurance; b) any amendments to the application(s) attached thereto; and d) any supplements, all of which are required by the Company for the plan, amount and benefits applied for.
2. No agent, broker or medical examiner has the authority to make or modify any Company contract or to waive any of the Company's requirements.
3. I HAVE READ, or have had read to me, the completed Application for Conversion of Group Life Insurance before signing below. All statements and answers in this application are correctly recorded, and are full, complete and true. I confirm that upon receipt of the contract I will review the answers recorded on the application. I will notify the Company immediately if any information in the application is incorrect. Caution: If your answers on this application are incorrect or untrue, the Company may have the right to deny benefits or rescind coverage under the policy and any riders attached to it.
4. I agree that with the acceptance of any policy issued on the life of the Proposed Insured, all rights under the Group Policy for such person are relinquished.
5. Corrections, additions or changes to this application may be made by the Company. Any such changes will be shown under "Service Office Endorsements". Acceptance of a policy issued with such changes will constitute acceptance of the changes. No change will be made in classification (including age at issue), plan, amount, or benefits unless agreed to in writing by the Applicant.

STATE DISCLOSURE AND SIGNATURE

Any person who, with intent to defraud or knowing that he/she is facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

To the best of my knowledge and belief, the answers given above are true and complete. I agree that: (a) this application, a copy of which will be attached to the policy when issued, will be a part of the policy; (b) by acceptance of any policy issued on the life of the Proposed Insured, all rights under the Group Policy for such person are relinquished; and (c) only an officer of the Company can make or alter a contract of insurance or bind the Company in any way.

WHEN INSURANCE TAKES EFFECT. The Insurance applied for on any person to be insured will take effect on the 1st day of the month following the termination of the group coverage if the first premium is paid during the conversion period and the lifetime of the Proposed Insured. Upon timely receipt by the Company of the conversion application and first premium, coverage will be available to the Owner(s) and/or any beneficiaries either under the group policy or the Company's new policy/certificate, but not under both.

Signed in _____ (state), this _____ day of _____ (month) _____ (year)

Signature of Proposed Insured
(Parent or Guardian if under 15 years of age)

Signature of Owner (If other than the Proposed Insured)
(Parent or Guardian if under 15 years of age)

Signature of Licensed Agent, Broker or Registered Rep.

Printed Name of Licensed Agent, Broker or Registered Rep.

APPLICABLE TO VARIABLE LIFE ONLY: I have reviewed the Application, Supplements, New Account Form and allocation forms and find the transaction suitable.

Signature of Registered Principal or Broker/Dealer

Printed Name of Registered Principal or Broker/Dealer

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 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

Contact Information

	Phone Number	Website/Email
Benistar		
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	jmoticka@benistar.com
Lincoln Financial Group		
Note: Only 31 days to elect coverage	1-800-423-2765	clientservices@lfg.com
Wellfleet		
Contact if you wish to keep your Wellfleet benefits.	1-855-664-5838	www.wellfleetworkplace.com/register
Aflac		
Brandon Harvey – Contact if you wish to keep your Aflac benefits.	336-991-4590	brandon_harvey@us.aflac.com
TIAA		
Retirement Plan	1-800-732-8353	tiaa.org/schedulenow
Social Security Administration		
Social Security Administration	Greensboro office – 877-319-3075 Reidsville office – 866-748-2091 Durham office – 888-759-3908 National office – 800-772-1213	ssa.gov
Medicare		
Medicare	1-800-633-4227	medicare.gov
Elon University		
Office of Human Resources	1-336-278-5560	elon.edu/u/fa/hr/

2024 Elon University Retiree Benefits Guide