



Retirement Packet

for Public School
Retirees

Provided By



Employee Benefits Division
Department of Finance & Administration
State of Arkansas

Retirement Overview

Upon retirement from your agency, you and your dependents are eligible to continue health coverage through several options which are outlined in detail below. ***The necessary forms must be submitted to Employee Benefits Division within 31 days of your retirement date.***

OPTION A – Health and Life Insurance Continuation under Retirement System

If you are eligible for a retirement benefit from one of the participating retirement systems*, you may continue your current health coverage in the retirement group by having the insurance premium deducted from your retirement check. Complete the form titled “Arkansas State Retiree Payroll Deduction Authorization” (#6200-f-1a) enclosed in this packet. **This is the form that notifies us of your intention to continue your health insurance.** Mail completed form to the Employee Benefits Division at the mailing address listed on the top. If your retirement benefit amount is inadequate to cover the insurance premiums, you will also be asked to set up a bank draft by completing the enclosed form, “Authorization Agreement for Pre-Authorization Payments (#6200-f-7b).”

OPTION B – COBRA Continuation ONLY

The Consolidated Omnibus Reconciliation Act of 1985 (COBRA) allows for continuation of health benefits after termination or retirement. If you are not eligible for retirement benefits from one of the participating retirement systems* and would like to retain your current health benefits, you may continue your health insurance for a period of 18 months as a COBRA Continuant. If you have not received a COBRA Election Form in the mail within 14 days of your last date of employment, please contact the Employee Benefits Division at (877) 815-1017 .

OPTION C – COBRA until retirement benefits begin

If you are eligible for retirement (i.e. have enough years of service) but will not immediately receive a retirement benefit, you may choose health insurance coverage under COBRA for a maximum of 18 months (or until you are eligible to receive a retirement check if within the 18 month period). To enroll under COBRA, please read and complete the COBRA Election form that will be mailed to your home. When your retirement benefit begins, you may change to the retirement group by contacting the Employee Benefits Division. *NOTE: It is the responsibility of the retiree to notify the Employee Benefits Division at least two (2) months before COBRA expires in order to make arrangements to change to the regular retiree group health insurance program.*

OPTION D – COBRA when retirement benefits are available

If you are eligible for retirement benefits from one of the participating retirement systems* when you retire, you may continue your health insurance through COBRA if you so choose. COBRA payments are made by bank draft. A bank draft payment is established by completing the “Authorization Agreement for Pre-Authorization Payments (#6200-f-7a)” included in this booklet. At the end of your COBRA benefit eligibility period (18 months) you will need to change to the retiree insurance group in order to continue your health insurance. It is very important to remember that you must remain on COBRA and make timely payments for the **entire** eligibility period to be eligible to begin insurance through the retirement system when COBRA coverage ends. *NOTE: It is the responsibility of the retiree to notify the Employee Benefits Division at least two (2) months before COBRA expires in order to make arrangements to change to the regular retiree group health insurance program.*

OPTION E – Waiver of Enrollment

If you do not wish to continue the Health Insurance coverage at all, please complete the “Waiver Form (8100-f-10)” box and then sign and date. Once completed, that form should be sent directly to Employee Benefits Division.

**Participating Retirement Systems are: Arkansas Public Employees Retirement System, Arkansas Teacher Retirement System, Judicial Retirement System, Arkansas Highway and Transportation Department Retirement System, and Alternative Retirement System.*

Public School Health Plan Options & Rates

Effective January 1, 2009, Self-Insured Health Plan

ARHealth Retirees	Base Monthly Premium	Subsidy	Plan Contribution	Total Monthly Retiree Cost
Retiree Only <i>(Not Medicare Eligible)</i>	\$654.85	\$76.59	\$106.04	\$472.22
Retiree <i>(Not Medicare Eligible)</i> & Spouse <i>(Not Medicare Eligible)</i>	\$1,309.66	\$76.59	\$106.04	\$1,127.03
Retiree <i>(Not Medicare Eligible)</i> & Child(ren)	\$1,047.74	\$76.59	\$106.04	\$865.11
Retiree <i>(Not Medicare Eligible)</i> & Spouse <i>(Not Medicare Eligible)</i> & Child(ren)	\$1,965.45	\$76.59	\$106.04	\$1,782.82
Retiree <i>(Not Medicare Eligible)</i> & Spouse <i>(Medicare Eligible)</i>	\$792.34	\$76.59	\$106.04	\$609.71
Retiree <i>(Not Medicare Eligible)</i> & Spouse <i>(Medicare Eligible)</i> & Child(ren)	\$1,186.65	\$76.59	\$106.04	\$1,004.02
Retiree Only <i>(Medicare Eligible)</i>	\$144.16	\$76.59	\$26.13	\$41.44
Retiree <i>(Medicare Eligible)</i> & Spouse <i>(Not Medicare Eligible)</i>	\$777.06	\$76.59	\$26.13	\$674.34
Retiree <i>(Medicare Eligible)</i> & Child(ren)	\$523.90	\$76.59	\$26.13	\$421.18
Retiree <i>(Medicare Eligible)</i> & Spouse <i>(Not Medicare Eligible)</i> & Child(ren)	\$1,156.80	\$76.59	\$26.13	\$1,054.08
Retiree <i>(Medicare Eligible)</i> & Spouse <i>(Medicare Eligible)</i>	\$273.32	\$76.59	\$26.13	\$170.60
Retiree <i>(Medicare Eligible)</i> & Spouse <i>(Medicare Eligible)</i> & Child(ren)	\$653.05	\$76.59	\$26.13	\$550.33

Public School Health Plan Options & Rates for COBRA Participants

Effective January 1, 2009: Self-Insured Health Plan

		HRA DISCOUNT				
Total Monthly Premium		One Healthy Discount Level I	One Healthy Discount Level II	Two Healthy Discounts Level I	One Healthy Discount Level I and One Level II	Two Healthy Discounts Level II
		\$10 monthly savings	\$20 monthly savings	\$20 monthly savings	\$30 monthly savings	\$40 monthly savings
ARHealth Employee Only						
Health Advantage	\$394.75	\$384.75	\$374.75	-	-	-
ARHealth - NovaSys	\$399.79	\$389.79	\$379.79	-	-	-
HD PPO - NovaSys	\$312.62	\$302.62	\$292.62	-	-	-
ARHealth Employee & Spouse						
Health Advantage	\$1,056.85	\$1,046.85	\$1,036.85	\$1,036.85	\$1,026.85	\$1,016.85
NovaSys	\$1,070.93	\$1,060.93	\$1,050.93	\$1,050.93	\$1,040.93	\$1,030.93
HD PPO - NovaSys	\$827.72	\$817.72	\$807.72	\$807.72	\$797.72	\$787.72
ARHealth Employee & Child(ren)						
Health Advantage	\$682.00	\$672.00	\$662.00	-	-	-
NovaSys	\$691.08	\$681.08	\$671.08	-	-	-
HD PPO - NovaSys	\$534.18	\$524.18	\$514.18	-	-	-
ARHealth Employee & Family						
Health Advantage	\$1,064.46	\$1,054.46	\$1,044.46	\$1,044.46	\$1,034.46	\$1,024.46
NovaSys	\$1,078.58	\$1,068.58	\$1,058.58	\$1,058.58	\$1,048.58	\$1,038.58
HD PPO - NovaSys	\$834.51	\$824.51	\$814.51	\$814.51	\$804.51	\$794.51



Phone: (501) 682-9656 Toll Free: (877) 815-1017 Fax: (501) 682-1168 <http://www.ARBenefits.org>

**Public School Retirees
 Enrollment Form**



1. Retiree Information: (please print)					
Last Name		First Name		MI	Gender <input type="checkbox"/> Married <input type="checkbox"/> Single
Home Address		City		State	Zip Code
Social Security #:	Date of Birth:	Home #:		Work #:	
Primary Care Physician:			PCP #	Current patient?	

2. Dependent Coverage Information:***						
S P O U S E	LAST NAME		FIRST NAME		MI	GENDER
	Social Security #:		Date of Birth:			
	Primary Care Physician:			PCP #	Current patient?	
D E P E N D E N T 1*	LAST NAME		FIRST NAME		MI	GENDER
	Social Security #:		Date of Birth		Full time student? **	
	Primary Care Physician:			PCP #	Current patient?	
D E P E N D E N T 2*	LAST NAME		FIRST NAME		MI	GENDER
	Social Security #:		Date of Birth		Full time student? **	
	Primary Care Physician:			PCP #	Current patient?	
D E P E N D E N T 3*	LAST NAME		FIRST NAME		MI	GENDER
	Social Security #:		Date of Birth		Full time student? **	
	Primary Care Physician:			PCP #	Current patient?	

* Please submit guardianship, court-ordered insurance responsibility or adoption papers on dependents that apply.
 **To be completed for dependents 19 and over only. Please submit proof of student status.
 *** Social Security # is not required to add coverage for a newborn.

3. I Wish To Enroll In the Following Plan:*	
A. Select your level of coverage: <input type="checkbox"/> Retiree Only <input type="checkbox"/> Retiree & Spouse <input type="checkbox"/> Retiree & Children	B. Plan Option: <input type="checkbox"/> ARHealth Retiree

*For Medicare eligible retirees, the ARHealth Plan will not include pharmacy benefits.
 Non-Medicare retirees and their non-Medicare dependents will be enrolled in the ARHealth HMO Plan.

Please include a check for your first month's premium with your Enrollment Form.

4. Other Medical Insurance:

1) Will you or any of your family members be continuing any other health insurance? Yes No

2) If Yes, what type of coverage? Medical Medicare, HIC # _____

If Medicare: Part A Effective Date / / or Part B Eff Date / /

If Medicare: Reason for Coverage: Over age 65 Disabled Kidney Disease

Please make sure EBD and your carrier has a copy of your Medicare card.

If you answered Yes to the question above, complete below: (Use additional paper if necessary)

Covered Person's Name	Coverage Type (single/family)	Effective Date	Policy Holder's Employer

Name/Address/Phone/Policy # of Health Ins Co.:

5. Please Read Before Signing:

I understand and agree that: (1) The information provided on this application is accurate and complete. (2) Any omissions or incorrect statements made by myself or anyone on this application may invalidate my and/or my dependents' coverage. (3) Coverage will become effective only on the date specified by the Insurer after the application has been approved by the Insurer **and after the first full premium has been paid.** (4) My signature authorizes Coordination of Benefits under this coverage with other insurance I have that is subject to coordination. (5) I hereby authorize deductions from my retirement earnings of any required insurance contribution. (6) By signing this enrollment form, I hereby certify that all the information provided is true and correct.

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION: On behalf of myself and anyone enrolled on or added to this application, I authorize any health care professional or entity to give the health plan/insurer and the employer or any of their designees, any and all records or information pertaining to medical history or services rendered to the health plan/insurer, for any administrative purpose, including evaluation of an application or a claim, and for any analytical or research purpose, including evaluation of an application or a claim. I also authorize on behalf of the health plan/insurer, the use of a Social Security Number for purpose of identification. A photocopy of this authorization will be as valid as the original.

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.

**I understand that if I decline to apply for coverage at retirement,
that I may not be eligible for coverage at a later date.**

Retiree's Signature: _____

Date: _____



Phone: (501) 682-9656

Toll Free: (877) 815-1017

Fax: (501) 683-0983

<http://www.ARBenefits.org>

**Change Form
 Status, Name and Address**



1. Employee Information: (please print)					
Last Name		First Name		MI	<input type="checkbox"/> Married <input type="checkbox"/> Single
Home Address		City	State	Zip Code	
SSN#	Date of Birth:	Home #:	Work #:		
If you would like benefit information sent to you by email, please print your email address:					
Primary Care Physician:		PCP #	Current patient?		

2. Change in Dependent Status (complete this portion if making any changes in dependent status): ***					
LAST NAME		FIRST NAME		MI	GENDER
Social Security #		Date of Birth		<input type="checkbox"/> Add	<input type="checkbox"/> Delete
Primary Care Physician:		PCP #	Full time student? **		
LAST NAME		FIRST NAME		MI	GENDER
Social Security #		Date of Birth		<input type="checkbox"/> Add	<input type="checkbox"/> Delete
Primary Care Physician:		PCP #	Full time student? **		
LAST NAME		FIRST NAME		MI	GENDER
Social Security #		Date of Birth		<input type="checkbox"/> Add	<input type="checkbox"/> Delete
Primary Care Physician:		PCP #	Full time student? **		

* Please submit guardianship, court-ordered insurance responsibility or adoption papers on dependents that apply.
 **For dependents 19 and over only. Please submit proof of student status.
 *** Social Security # is not required to add coverage for a newborn.

3. Change In Coverage (complete this portion if making any of the following changes):	
Change in Status:	Reason for Change:
<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Children <input type="checkbox"/> Family <input type="checkbox"/> Cancel Coverage	<input type="checkbox"/> Birth - Date: _____ <input type="checkbox"/> Death - Date: _____ <input type="checkbox"/> Divorce - Date: _____ <input type="checkbox"/> Marriage* - Date: _____ <input type="checkbox"/> Other: _____
<input type="checkbox"/> Add Dependent <input type="checkbox"/> Delete Dependent <input type="checkbox"/> Name <input type="checkbox"/> Address	

* Please attach Marriage License; Maiden Name if applicable

4. To Be Completed By Agency/School District:	
Agency/School District Name:	Agency/School District #:
Effective Date of Change:	Employee #:
Representative Signature:	Date:

Employee Signature: _____ Date: _____

