



Pre-65 & Medicare-Eligible Retiree Life Insurance Decrease Coverage or Cancellation Form

Instructions:

- 1) Print clearly with blue or black ink and provide complete information. (Missing information causes delays.)
- 2) For each coverage, check the appropriate box(es) to reduce or cancel coverage
- 3) Sign and date the form.
- 4) **MAIL** your form to the UNM HR Benefits Office at 1700 Lomas Blvd NE, Suite 1400, Albuquerque, NM 87131 or **FAX** to 505-277-2278 for processing.

Changes are effective the first day of the month after your completed Form is received by UNM HR Benefits.

EMPLOYEE INFORMATION

Name (FIRST MI LAST)		UNM Banner ID or Last 4 digits of your SSN	Date of Birth (MM/DD/YYYY)
Address:		Phone Number with area code:	
Group Policy Number 681589	Coverage Classifications:	Class 4 – Pre-65 Retiree Class 5 – 65+ Retiree	

All cancellations or decreases in coverage are final once submitted to UNM HR Benefits office. You may not increase or enroll in Retiree life insurance benefits in the future. Please consider your changes carefully.

BASIC TERM LIFE INSURANCE *(Pre-65 or Medicare-Eligible)*

Pre-65 Retiree (Class 4)			Medicare-Eligible Retiree (Class 5)		
Basic Term Life	1x Pre-Retirement Annual Salary	<input type="checkbox"/> Cancel Coverage	Basic Term Life	\$4,000	<input type="checkbox"/> Cancel Coverage

SUPPLEMENTAL TERM LIFE INSURANCE *(Pre-65 or Medicare-Eligible)*

Pre-65 Retiree (Class 4)		Medicare-Eligible Retiree (Class 5)	
<u>Options to decrease or cancel Supplemental Term Life:</u>	<input type="checkbox"/> Decrease Indicate decreased coverage Tier _____	<u>Options to decrease or cancel Supplemental Term Life:</u>	<input type="checkbox"/> Decrease Indicate decreased coverage Tier _____
Tier 1 (1x Pre-Retirement annual salary) Tier 2 (2x Pre-Retirement annual salary) Tier 3 (3x Pre-Retirement annual salary)	<input type="checkbox"/> Cancel All Supplemental Coverage	Tier 1 - \$2,000, or Tier 2 - \$4,000, or Tier 3 - \$6,000	<input type="checkbox"/> Cancel All Supplemental Coverage

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Changes will not be accepted without signature and date on Page 2

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Retiree Certification

By signing below:

- I understand and agree that: 1) If I decrease or cancel retiree life coverage now my changes made are final and I cannot re-enroll in 2) Insurance will go into effect and remain in effect only in accordance with the provisions, terms and conditions of the insurance policy; 4) Only the insurance policy(ies) issued to my employer can fully describe the provisions, terms, conditions, limitations and exclusions of my insurance coverage; 5) In the event of any difference between the enrollment form and the insurance policy, I agree to be bound by the insurance policy; 6) No insurance will be valid or in force if I am not eligible in accordance with the terms of the group policy(ies) as issued to my employer; and 7) If group participation requirements are required and are not met, the policy(ies) may not be implemented and the coverage I have elected may not be in force.
- I authorize payroll deductions from my wages to cover my cost of coverage where applicable. I understand that any premium amounts indicated on this form are estimates, which are subject to change based on the final terms of the applicable policy, and may be subject to ongoing change based on my age and/or earnings. I also understand that rates and benefits may be changed by the insurer.
- If you knowingly make a false statement on your Enrollment Application, or file a false claim, such application or claim may be retroactively rescinded to the date of the application or claim. Any premiums collected from the Participant for coverage that is later revoked due to a fraudulent application may be refunded to the Participant by the Plan. If a claim is paid by the Plan and it is later determined that the claim should not have been paid due to a fraudulent application or claim, the Participant may be responsible for full reimbursement of the claim amount to UNM.
- I understand that my signature authorizes the University of New Mexico to make any necessary deductions from my pay through payroll deduction. I understand and accept that if I fail to pay my account the University may refer my delinquent account to a collection agency. I further understand that I am responsible for paying the collection agency fee which may be based on percentage, at a maximum of 40% of my delinquent account, together with all costs and expenses, including reasonable attorney's fees, necessary of the collection of my delinquent account. Finally, I understand that my delinquent account may be reported to one or more of the national credit reporting bureaus.

Signature _____ Date _____

It is your responsibility to review your **Benefits Statement in LoboWeb** and your premiums on your Bursar's bill. Report any issues or discrepancies to 277-MyHR (6947).

HR SERVICE CENTER USE ONLY

HR Service Rep Initials: _____

Form Complete: Yes No

If no, reason: _____

HR BENEFITS USE ONLY

Appt %: _____ BCAT: _____

Annualized Salary: <35 35-50 >50

Deduction starts: _____