TEAMCARE®
A CENTRAL STATES HEALTH PLAN

RETIREE HEALTH PLAN POSTPONEMENT FORM

MEMBER NAME:		MEMBER ID:	8	0	6						
ADDRESS:											
CITY:	STATE:	ZIP CODE:									

You and your family (if applicable) may elect on a one-time basis to voluntarily postpone Retiree Health Plan coverage to a later date provided there is other insurance coverage in effect. If you are on the TeamCare Retiree Health Plan and wish to voluntarily postpone your coverage to a later date, please complete this form.

You must submit proof of your other insurance to qualify for postponement of your TeamCare Retiree Health Plan coverage.

I WANT TO VOLUNTARILY WAIVE RETIREE HEALTH PLAN COVERAGE AND POSTPONE COVERAGE TO A LATER DATE.

Check one box (A, B, C or D) below:

A. ☐ POSTPONE MYSELF ONLY, effective: _____

B. ☐ POSTPONE MYSELF AND MY SPOUSE, effective: _____

C. ☐ POSTPONE MY SPOUSE ONLY, effective: _____

D. ☐ POSTPONE MY DEPENDENT CHILDREN ONLY (UPS RU/RV Plans), effective: _____

NOTE:
- Eligibility for Medicare coverage makes you ineligible for Retiree Health Plan coverage from TeamCare even if you decline Part B. You will be held responsible for reimbursing TeamCare for any claims paid after the Medicare eligibility date. Under no circumstances may you voluntarily postpone Retiree Health Plan coverage beyond your normal Medicare eligibility date (age 65 at present).
- Coverage will be terminated, effective the 1st of the month following receipt of the postponement or termination request.

I understand that when I reactivate my voluntarily suspended TeamCare Retiree Health Plan coverage, either for myself and/or my family, I must submit documentation to TeamCare (a letter or verification of group health plan coverage from the insurance company) that will confirm continuous health insurance coverage beginning on the day that I suspended TeamCare Retiree Health coverage and ending on the date that I want coverage to be reinstated. I also understand that at the time of reactivation, I will be responsible for paying the prevailing monthly retiree contributions, based upon my age on my retirement date, retroactively to the date that my other insurance coverage ceased.

My signature below acknowledges that I understand the effect, to myself and my family, of my decision to voluntarily suspend the Retiree Health Plan coverage at this time, and to postpone coverage to a later date.

MEMBER SIGNATURE:	DATE:

Return the completed form to TeamCare as directed below.

UPLOAD	MAIL	FAX	CALL
Message Center at MyTeamCare.org	TeamCare PO Box 5109 Des Plaines IL 60017-5109	847-518-9752	Questions? 800-TEAMCARE

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