Retirement Insurance Benefit
Effective 9/1/2024

Name _____ **Munis ID#** _____

Work Location _____ **Job Title** _____

Upon retirement I will be electing: Plan #1 Single_____Two-Party_____Family_____Coverage
Plan #2 Single_____Two-Party_____Family_____Coverage

I have reviewed the Retiree Health Insurance Plan guidelines offered by the Clarksville Montgomery County School System, and understand the benefits provided to me.

I understand that the Board of Education contributions toward my medical insurance will continue until I or my dependent(s) turn age 65, or become eligible for Medicare or a maximum of 10 years whichever occurs first. Neither I, nor my insured dependent(s) are currently enrolled in Medicare.

Any increase in the cost of the insurance during my eligibility period will be my sole responsibility. The Board of Education will be contributing a fixed amount each month to the premium cost of my insurance. Plan #1 premiums are: $355.75 a month for a single policy, $697.46 a month for a two-party policy and $947.92 for a family policy. Plan #2 premiums are: $326.21 a month for a single policy, $639.57 a month for a two-party policy and $869.25 for a family policy.

I am aware that this retirement incentive is for medical insurance only. I may elect Dental and Vision insurance through COBRA for a maximum of 18 months with Blue Cross Blue Shield.

Further, I understand that I must receive a monthly benefit from TCRS in order to qualify for the retiree medical insurance. It is my responsibility to notify the CMCSS Benefits Office if I elect to cancel or postpone my TCRS benefits.

This form must be signed and submitted through the retiree portal by **March 1, 2025.**

I intend to retire at the end of school year 2024/2025, and will qualify for the Retirement Incentive.

_____ _____
Signature **Date**