Medicare Eligibility
Acknowledgement
CMCSS Retiree Insurance

Name_____ Munis ID#_____

Work Location_____ Job Title_____

I acknowledge that I am not currently eligible for Medicare nor is any dependent that will be covered under my medical plan.

I understand that when I or a covered dependent become eligible for Medicare (due to disability or age 65), I or said dependent are no longer eligible to remain enrolled in the CMCSS retiree medical plan.

I understand that it is my responsibility to contact the Benefits Office of CMCSS (931.920.7810) if I or any covered dependent become eligible for Medicare before age 65.

I understand that I and any dependents will automatically be removed from the CMCSS Retiree medical plan on the 1st day of the month of reaching age 65.

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Signature Date