Retirement Insurance Benefit
Effective 9/1/2018

Name _____ **Munis ID#** _____

Work Location _____ **Job Title** _____

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. This amount is $294.42 a month for a single policy and $577.22 a month for a two-party policy.

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

This form must be signed and returned with the attached retirement form by **March 1, 2018 to the Human Resources Department.**

I intend to retire at the end of school year 2017/2018, and will qualify for the Retirement Incentive.

_____ _____

Signature **Date**