City of Crystal Lake
Notice of Intent to Retire

Name: _____ Date Submitted: _____

Dept./Division: _____

I am planning to retire on: _____

☐ I would like to continue my group health insurance with the City of Crystal Lake and I am electing:

☐Single ☐Single +1 ☐Family

☐ Will Medicare cover you or your spouse at the time of your retirement? Yes___ No___

☐ I would like to have the premium cost deducted directly from my monthly Police/Fire Pension check.

☐ I would like to have the premium cost deducted directly from my monthly IMRF benefit payment (please fill out IMRF Form 7.10 "Health Insurance Continuation through Employer-Premium Deduction Authorization").

☐ I would like to continue my health insurance and I will submit the premium payment to the City of Crystal Lake prior to the first of each month.

☐ I would like to <u>decline</u> to continue my health insurance with the City of Crystal Lake and I acknowledge I am not eligible for Health Insurance in the future.

……

I understand if I choose not to continue the group Health Insurance with the City of Crystal Lake at this time, under current law, this is an irrevocable election and I will not have another opportunity to elect coverage. I understand that I am responsible for the monthly insurance premiums for the health insurance I elect and that it may increase or decrease whenever the group insurance rates change.

I further acknowledge that I will receive my final paycheck (including payment for any accrued, but unused vacation, compensatory time and sick if applicable) on the next regular scheduled pay date following my retirement date.

_____ _____

Employee Signature Date

_____

Employee Personal E-Mail Address

_____ _____

Human Resources Signature Date