CHARLOTTE-MECKLENBURG SCHOOLS RETIREMENT FORM

Employee's Name ______________________________ **Social Security #** ______________________________

Please complete this section if you are *Retiring*
I wish to RETIRE as an employee of the Charlotte-Mecklenburg Schools at the close of the day on ______________________
Specific Job Title/Position ______________________
School/Dept/Area ______________________

IMPORTANT
( ) I understand that I must come to the Benefits Department to complete the Retirement paperwork and this form.

ALL EMPLOYEES MUST COMPLETE THE FOLLOWING INFORMATION

Life Insurance Your group insurance coverage terminates the last day of the month in which you retire. To convert this coverage to an individual policy, application must be made within 31 days of your retirement date.

Health Insurance *Teachers' and State Employees' Comprehensive Major Medical Plan*

- I am eligible for health insurance membership in the retired group. (I understand I am responsible for dependent coverage premiums.)

Dental Insurance

- I understand I will receive information regarding my COBRA rights and I am responsible for all continued coverage premiums. I understand that to be eligible for COBRA I must be enrolled in the dental plan at Retirement.

Vision Insurance

- I understand I will receive information regarding my COBRA rights and I am responsible for all continued coverage premiums. I understand that to be eligible for COBRA I must be enrolled in the vision plan at Retirement.

I have read the above benefit information and understand that it is my responsibility to elect coverage and pay the required premiums within the specified time frame.

Employee's Signature ______________________ Date ______________________ Telephone # (______)______________________

Forwarding Address ____
(House/POB #) (Street Name) (City) (State) (Zip Code)