



Post-Retirement Option (PRO) Agreement Form

Agency: _____

Agency Contact Name and Phone Number: _____

Retiree/Employee Name and Employee ID: _____

Employee Retirement/Separation Date: _____

Select Retirement Plan:

MSRS

PERA

Start Date: _____

Anticipated End Date: _____

Conditions of PRO Appointment

Job Classification: _____

Bargaining Unit: _____ Rate of Pay: _____

Eligible for Holiday, Vacation, and Sick Leave Benefits?

Yes

No

Describe schedule and hours for PRO Appointment

EMPLOYER CONTRIBUTION TO SEGIP HEALTH INSURANCE OR MSRS HCSP

(Select all that apply below and complete table on next page)

SEGIP coverage with a partial employer contribution, because the employee is scheduled to work 1,044 hours in any period of 12 consecutive months and the employee has not waived (declined) coverage. No HCSP contribution allowed.

SEGIP coverage with an employer contribution for the first three months or as required under the Employer Shared Responsibility provision of the Affordable Care Act. HCSP contribution is allowed for any month during which the employee does not receive a contribution for health coverage.

Employer contribution to an MSRS Health Care Savings Plan account. Estimated amount \$ _____. The estimate is based on the dates and schedules above and current insurance provisions; subsequent changes may affect the amount contributed.

Not eligible for any. Reason: _____

Check one box for each month of the scheduled PRO:

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
SEGIP Insurance Coverage												
H CSP Contribution												
Not Eligible for Either												

Appointing Authority: Send this agreement to the employee’s retirement system for review and first signature (MSRS: eligibility.team@msrs.us) or (PERA: Amy.Brandenburg@mnpera.org).

SIGNATURES

MSRS/PERA

Is the retiree/employee eligible for full retirement as of the Employee Retirement/Separation date above?

Yes

No

MSRS/PERA Signature: _____ Date Signed: _____

Retiree/Employee

I confirm that I meet all of the eligibility criteria for participation in the Post-Retirement Option program. I understand and agree that the PRO position is in the unclassified service per MS 43A.346, and that my PRO appointment may be terminated at any time at the discretion of the appointing authority. I understand that although the position is in the unclassified service, it is not covered by the Minnesota State Retirement System unclassified plan. I understand and accept the conditions of the PRO appointment described in this Agreement, in HR/LR Policy #1408 Post-Retirement Option, and in M.S. 43A.346.

Employee/Retiree Signature: _____ Date Signed: _____

Appointing Authority

I confirm that the agency has verified the employee’s eligibility for this PRO appointment. I understand the conditions of the PRO appointment described in this agreement, in HR/LR Policy #1408 Post-Retirement Option, and in M.S. 43A.346.

Appointing Authority Signature: _____ Date Signed: _____

Appointing Authority: Send a fully signed copy of this agreement and any subsequent agreements to:

- The employee’s retirement system (MSRS: eligibility.team@msrs.us) or (PERA: Amy.Brandenburg@mnpera.org);
- MMB Employee Insurance Division (fax: 651-797-1313); AND
- MMB SEMA4 HR Specialist (PRO_Appt.MMB@state.mn.us).