NOV Application for U.S Retiree Medical Coverage

Date of Application: _____

Employee Name:		**Person Number:**	
Proposed Retirement Date			
Are you requesting continued medical coverage?	☐ Yes ☐ No		
If No is checked, I understand that I am declining retiree medical coverage and will only be offered medical coverage upon retirement through COBRA.	_____ Applicant Signature & Date		
Do you want to change medical plan at retirement?	☐ Yes ☐ No		
What coverage tier are you requesting for continued medical coverage?	☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family		
Name(s) of spouse and/or dependent children to be covered (spouse and/or children must be covered prior to retirement date):			

Initial on lines below:

I understand that NOV is offering retiree medical coverage based on the following criteria:

a. The Employee must attain at least sixty (60) years of age at time of retirement; and
b. The Employee must have completed at least ten (10) years of total employment with a Participating Employer, which shall be determined based on the Employee's "adjusted service date" as reflected in the Employer's human resources information system or "HRIS" system; and
c. The Employee must have completed at least five (5) years of continuous employment with a Participating Employer as of the Proposed Retirement Date.

_____ I certify that I will have met the above criteria by my Proposed Retirement Date and understand that I cannot revoke my application.

_____ I understand that I will have to sign a Release Agreement to participate in the U.S. Retiree Medical Coverage.

_____ In the case of a voluntary termination, I understand that the notice period will be three months, however, that (i) the Employer shall not be required to provide any additional compensation to me if the Administrator designates a Retirement Date that occurs prior to the Proposed Termination Date, and (ii) the Retirement Date designated by the Administrator may occur up to three (3) months after the Proposed Termination Date.

_____ I understand that I must continue to work for the Employer in "good standing" until my Termination Date.

_____ I understand that coverage will end for me and my dependents when I turn age sixty-five (65) and become eligible to participate in Medicare. I understand that coverage will also end if I am eligible or become eligible to receive comprehensive medical coverage under another employer's group health plan, if I provide services to a competitor of NOV, or if I fail to pay the required premiums.

_____ I have reviewed the "U.S. Retiree Medical Coverage Plan" document and agree to the coverage provisions including the conditions in which retiree medical coverage will cease.

Applicant Signature:		Date:	
Supervisor's Signature			
Supervisor's Name		Date:	

HR APPROVAL: I confirm I have received the signed Release Agreement and will notify Benefits if the agreement is revoked for any reason.

HR Name: Date:

HR Signature: _____

BENEFITS APPROVAL

Approval Date: _____ Actual Retirement/Termination Date:

Date Retiree Medical coverage begins: