



Retiree Health Enrollment

Selection and Deduction Agreement for Dental/Vision/Life/Dependent Coverage

Name (PRINT): _____ Date of Birth: _____
(Last) (First)

S S #: _____ Phone: _____ Email: _____

Address: _____
(Street) (City and State) (Zip)

I want to change my current benefits as indicated below. Please enroll in one of the following retirement benefits. **Refer to current rate sheet for premiums.**

Pension Plan: STRS PERS

▪ **Medical Waiver** Waiver form and **proof of other group coverage** attached. OPT OUT

▪ **Certificated Medical** *Health Net:* Health Net Seniority Plus AARP

Kaiser: Kaiser Senior Advantage
▪ **Classified/Mgmt Medical** Kaiser Senior Advantage WHA Sutter Health Futuris Care
If eligible, the District or agent will reimburse me based on my eligibility of 100% or 50%.

▪ **Medicare** All retirees and/or their dependents are eligible for Medicare Part A and B upon reaching age 65. To protect your insurance coverage under district's medical plans you and your dependents **MUST** enroll in Medicare A and B benefits at the Social Security Office.

▪ **Dental**
 I elect Dental coverage. I do not elect coverage
Retiree Only, Two-Party or Family
 Premier Access Delta Dental

▪ **Vision** I elect Retiree Only I elect Two-Party I do not elect coverage
 I elect Family

▪ **Life** I elect Life Insurance. I do not elect coverage
Retiree Only, Two-Party, Family

▪ **Dependent Coverage** I elect dependent coverage. I do not elect coverage

NAME OF DEPENDENT SOCIAL SECURITY NO. DOB RELATIONSHIP

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I agree that STRS/PERS shall deduct monthly from my pension the following amounts: \$ _____

I understand and agree that my STRS/PERS pension will be reduced by my selected options and/or any health deductions. I also understand if my STRS/PERS pension **does not cover** the total amount now or any time in the future, I will need to make personal payments to the District or District's agent. Changes to your selections can be made only during Open Enrollment or with a qualifying event.

Signature

Date

INTERNAL USE : Current Age _____ Approved STRS/PERS _____ Years of Qualified Service _____
Last Day Worked: _____ Effective Date for Selection(s): _____