DELTA DENTAL

www.deltadentalid.com

Group Insurance Benefits Request

Idaho School Retirees

TO BE COMPLETED BY THE EMPLOYER

Retirees Name _____ Subscriber Number _____

Birthdate _____

Address _____ Phone Number _____

City/State/Zip _____ Date of Retirement _____

Coverage paid by School District through _____, 20____

Signed, School District Official _____

School District's Name and Number Post Falls School District #273

School District's Address PO Box 40, Post Falls, ID 83877-0040

Total monthly dental premium: $_____ Total back premiums\adjustments: $_____

Sufficient sick leave available to cover 1st payment due? Yes ☐ No ☐

Sufficient sick leave available to cover back premiums/adjustments? Yes ☐ No ☐

Please pay the Dental Care Plan premium of $_____. I understand that rates, benefits and continuing eligibility for coverage for me and my dependents are all subject to the Master Contract between the School District and Delta Dental of Idaho. I understand the School District will notify me of any rate changes. I realize that should the Contract between the School District from which I retired and Delta Dental of Idaho be terminated, my coverage through Delta Dental of Idaho will terminate.

Please include the following eligible dependents for coverage under the Dental Care Plan.

Dependent Spouse's Name_____Birthdate_____

Dependent Child's Name and Birthdate:

Name_____ Birthdate_____ Name_____Birthdate_____

Name_____ Birthdate_____ Name_____Birthdate_____

I understand that if coverage is voluntarily terminated for myself, it can never be reinstated. I may add or terminate my dependents only when a status change has occurred. Dependent additions are subject to the contractual limitations stated in the contract between Delta Dental and the School District.

Signature Date

_____ _____

Instructions:

Complete this form, including signatures by the School District Official and Retiree, and monthly premium amount. Send to Delta Dental of Idaho by the tenth of the month preceding retirement. Delta Dental of Idaho will notify the Public Employee Retirement System.

DELTA DENTAL OF IDAHO
P.O. Box 2870
Boise, Idaho 83701