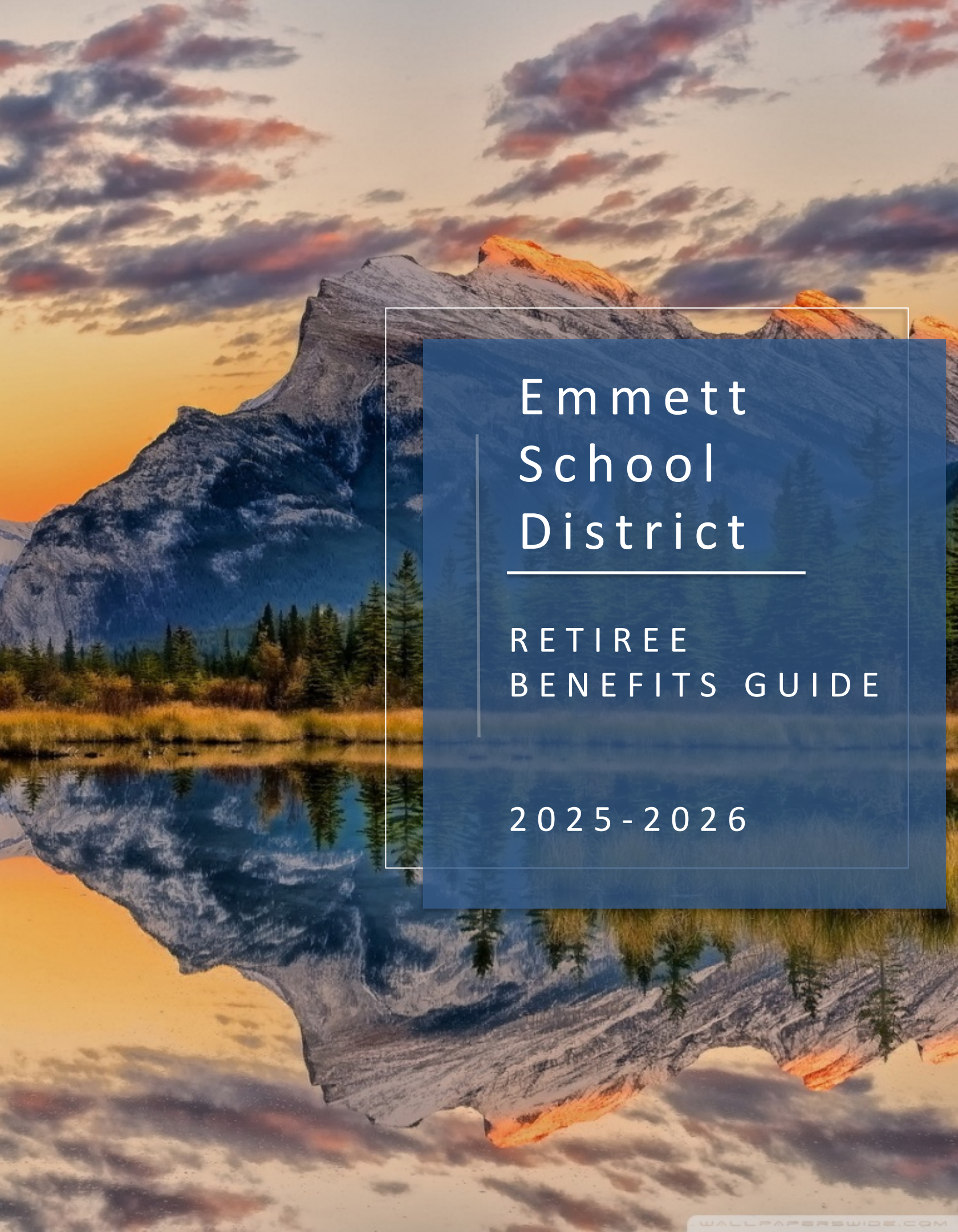

Emmett School District

RETIREE BENEFITS GUIDE

2025-2026

Retiree Benefit Guide 2025-2026

This guide contains information regarding the Medical, Dental, Vision and Life benefits offered to you as an under Age 65 Retiree of the Emmett School District. If you have any questions about the information provided, please contact our benefit consulting team at Acrisure for assistance at (208) 765-2620.

Not Making Changes:

- If you do not need to make changes to your current plans, you will not need to complete any of the forms in this packet. All your plans will remain the same with new monthly rates beginning on September 1, 2025.

Making Changes:

- To change plans or add/remove dependents, you must complete the corresponding Medical, Dental, Vision or Life forms included in this packet. Please be sure to include your signature and indicate the changes on the top of the form.

  * You are only able to make changes to medical, dental, vision and life benefits if you elected them at your initial retirement.

- If you have your premiums deducted from your unused sick leave or PERSI retirement, please understand that any changes you make to your enrollment are subject to PERSI review and eligibility. You may be required to pay for your premiums by direct bill if you do not have funds available.

- Contact PERSI if you need to view your account balance.

- **If you or your spouse are turning 65 this year, please contact Acrisure at (208) 765-2620 for more information about the Retiree Benefits for Medicare-eligible Retirees.**

All forms must be completed and returned to Human Resources by August 15, 2025.
You can mail, fax, or email the forms to Human Resources.

By Mail: Human Resources
119 N Wardwell Avenue
Emmett, ID 83617

By Fax: (208) 365-2961
Attention: Cynthia Mecham

By Email: cmecham@isd221.net

PLEASE NOTE:

› Independent School District of Emmett will continue using **Regence** for health coverage this year. Vision will be switching over to United Heritage Life Insurance through VSP. No Changes to the dental plans.

Insurance Premiums

Medical – Regence $500 Deductible PPO Plan

	Retiree Premium
Employee Only	$811.20
Employee & Spouse	$1,539.00
Employee & 1 Child	$1,109.60
Employee & 2+ Children	$1,284.00
Family	$1,767.60

Medical – Regence $3,200 Deductible HSA Plan

	Retiree Premium
Employee Only	$686.10
Employee & Spouse	$1,273.00
Employee & 1 Child	$918.30
Employee & 2+ Children	$1,062.70
Family	$1,462.40

Delta Dental

	Retiree Premium
Employee Only	$36.35
Employee & Spouse	$80.60
Employee & 1 Child	$69.85
Employee & 2+ Children	$103.90
Family	$139.05

Willamette Dental *Dental Blue Connect*

	Retiree Premium
Employee Only	$53.49
Employee & Spouse	$115.76
Employee & 1 Child	$102.82
Employee & 2+ Children	$153.08
Family	$205.01

Vision

	Retiree Premium
Employee Only	$7.83
Employee & Spouse	$15.69
Employee & Child(ren)	$16.78
Family	$26.81

2025 – 2026 Medical Plans

Plan Highlights:	Option 1: Regence $500 PPO	Option 2: Regence $3,300 HSA
Deductible (Calendar Year) Individual Family	 $500 $1,000	 $3,300 $5,000
Coinsurance (In-Network) *Cost-sharing after deductible is met*	Plan pays 70% / You pay 30%	Plan pays 80% / You pay 20%
Out-of-Pocket Maximum *(Once member reaches this, plan will pay 100% for remainder of calendar year)* Individual Family	*(Includes Deductible + Coinsurance + Copays)* $5,000 $10,000	*(Includes Deductible + Coinsurance)* $5,500 $11,000
Physician Office Visit	**No Deductible** **Primary Care:** $30 copay **Specialist:** $45 copay	 **Primary Care:** $15 (after deductible) **Specialist:** $40 (after deductible)
Preventive Care	Covered 100%	Covered 100%
Diagnostic Labs / Imaging	No deductible up to $400, then applied to deductible + coinsurance	Applied to deductible + coinsurance
Hospitalization/Maternity	Applied to deductible + coinsurance	Applied to deductible + coinsurance
Emergency Room	30% after $300 copay per visit (waive if admitted)	$300 Copay + deductible + coinsurance
Pharmacy / RX Preferred Generic: Preferred Brand Name: Non-Preferred Brand Name: Specialty:	 $10 (deductible waived) 25% 50% N/A	**Deductible & OOP combined w/Medical** $10 (deductible waived) $30 (after ded) $60 (after ded) $150 (after ded)

Regence PPO vs. Regence HSA

Regence PPO

- ✓ Members pay flat copays for physician office visits and most prescriptions.
- ✓ Great choice for members who have ongoing medical costs and prefer copays and upfront coverage for services.

Regence HSA

- ✓ The Regence HSA is a high-deductible health plan. Members receive coverage for medical services once they reach their deductible.
- ✓ Great choice for members with minimal medical expenses each year who want to save money on health insurance premiums.

- ➢ Both plans include 100% coverage for Preventive Care Services with no copay and no deductible.

Delta Dental

PROVIDER NETWORK	PPO	PREMIER
Annual Deductible (Individual / Family)	None	None
	Plan Pays:	Plan Pays:
Preventive Care *(Exam, cleanings, x-rays)*	70-100%	70-100%
Basic Procedures *(Fillings, extractions, root canal)*	70-100%	70-100%
Major Procedures *(Crowns, bridges, dentures)*	50%	50%
Annual Maximum Benefit *(Per Member)*	**$1,000**	**$1,000**

Visit www.deltadentalid.com to view network providers, claims, and member discounts

Willamette Dental (Dental Blue Connect)

****Must go to the Willamette Dental Clinic for services****

BENEFITS	COPAY
General Office Visit	$15 Copay
Annual Benefit Maximum	No Annual Maximum
****Must go to the Willamette Dental Clinic for services****	
Preventive (Cleanings, X-Rays, Exam)	Covered 100% after Copay
Fillings	$15 Copay
Extraction / Surgical Extraction	$15 Copay / $75 Copay
Root Canal	$50 Copay
Crowns & Bridges	$150 Copay (each service)
Dentures	$200 Copay
Orthodontia	$1,500 Copay
Nitrous Oxide	$20 Copay
Dental Implant	N/A

Vision

United Heritage Insurance

In Partnership with VSP®

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
Your Coverage with a VSP Provider			
WELLVISION EXAM	• Focuses on your eyes and overall wellness	$10	Every 12 months
PRESCRIPTION GLASSES		**$25**	See frame and lenses
FRAME*	• $170 featured frame brands allowance • $150 frame allowance • 20% savings on the amount over your allowance • $80 Walmart®/Sam's Club®/Costco® frame allowance	Included in Prescription Glasses	Every 12 months
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	Included in Prescription Glasses	Every 12 months
LENS ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 30% on other lens enhancements	$0 $95 - $105 $150 - $175	Every 12 months
CONTACTS (INSTEAD OF GLASSES)	• $150 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation), billed amount not to exceed $60		Every 12 months
EXTRA SAVINGS	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to **vsp.com/offers** for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.		
	Routine Retinal Screening • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam		
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		

YOUR COVERAGE GOES FURTHER IN-NETWORK

With so many in-network choices, VSP makes it easy to get the most out of your benefits. You'll have access to preferred private practice, retail, and online in-network choices. Log in to **vsp.com** to find an in-network provider. Your plan provides the following out-of-network reimbursements:

Exam ..... up to $45	Lined Bifocal Lenses ..... up to $50	Progressive Lenses ..... up to $50
Frame ..... up to $70	Lined Trifocal Lenses ..... up to $65	Contacts ..... up to $105
Single Vision Lenses ..... up to $30		

You do not need a card to access your VSP benefits. Simply give your Eye Clinic your Name and DOB. Dependents covered on vision will be accessed under the Employee's Information.

FIND VSP PROVIDERS AT: WWW.VSP.COM

VSP Vision care for life

Retiree Life Insurance

Employer Paid Life Insurance	
Options	**Retiree Monthly Premium**
$30,000	**$105.30**
$20,000	**$70.20**
$10,000	**$35.10**
$5,000	**$17.55**

* Only available to Retirees who opted-in prior to retirement

Benefit Contact Information

Benefit Plan	Carrier Name	Website	Phone Number
Benefit Advocates	Acrisure	acrisure.com/northwest	877.765.2620
Medical	Regence	regence.com	888.494.2583
Dental	Willamette Dental	willamettedental.com	855.433.6825
Dental	Delta Dental of Idaho	deltadentalid.com	800.356.7586
Vision	VSP Vision Plan	vsp.com	800.877.7195
Life /LTD	United Heritage Life	unitedheritage.com	800.830.1140

Regence BlueShield of Idaho, Inc.

Regence BlueShield of Idaho is an Independent Licensee of the Blue Cross and Blue Shield Association

Retiree Insurance Benefits Request Form

This form is to be completed and signed by both the Retiree and their participating school district. The school district needs to provide a copy to Regence BlueShield of Idaho and PERSI **prior to the 10th of the month before retirement.**

Retirees under age 65 without Medicare: Retirees who are under the age of 65 will have the same benefits offered to the Active school district employees. If at any time you acquire Medicare for any reason, you **must** notify Regence BlueShield of Idaho. Acquiring Medicare disqualifies you to remain on the active school district plan. If you had dental coverage through Regence BlueShield of Idaho as an active employee, you will be allowed to continue that dental coverage as a Retiree as long as your school district offers that benefit to their employees. Please note: If you have Medicare due to disability, you are not eligible to remain on the active school district plan.

Retirees and/or Spouses over age 65: Retirees and/or spouses over the age of 65 are eligible to be enrolled in Regence BlueShield of Idaho's Public School Retiree plan. To be eligible for this plan, you and/or your spouse must have both parts Medicare A and B.

Effective Date of Coverage _____

Retiree's Name		**Date of Birth (mm/dd/yyyy)**
School District Retiring From	**School District Address**	
Subscriber Identification Number	**Medicare Beneficiary Number**	
Address	**City/State/Zip**	
Phone Number (including Area Code)	**Date of Retirement (mm/dd/yyyy)**	**Last Month of Coverage Paid by Employer**
Eligible Dependent Coverage		
Dependent Spouse Name	**Medicare Beneficiary Number**	**Date of Birth (mm/dd/yyyy)**
Dependent Child's Name	**Medicare Beneficiary Number**	**Date of Birth (mm/dd/yyyy)**

Type of Coverage: ❒ Retiree ❒ Retiree/Dependent ❒ Retiree/2+ Dependents

Total Monthly Premium Charge:_____

Please note the following about your plan options:

Public School Retiree Preferred Plan: This is a medical only policy and does not include benefits for dental, vision or prescription drugs.

Regence Medicare Script™ (PDP - Prescription Drug Plan): If you select the Public School Retiree Preferred Plan, you are eligible to apply for Regence Medicare Script prescription drug coverage. Retirees **must** be covered under the PSR plan in order to have this group Medicare Script plan. You must complete the Medicare Script (PDP) Enrollment Form for this coverage (one per applicant). Contact your Regence Membership Account Rep for an enrollment form. If you decline coverage on the PSR Preferred plan, you are not eligible for the group Medicare Script coverage, but **can** select an **Individual** Medicare Script plan through Regence.

MedAdvantage + Rx Classic PPO Coverage: This option includes medical, dental, vision and prescription drug coverage and requires the completion of the group MedAdvantage (PPO) Enrollment Request Form (one per applicant). Contact your Regence Membership Accounting Rep for an enrollment form. *****NOTE: Not all Idaho counties are eligible for the MedAdvantage + Rx Classic PPO plan due to a lack of network coverage. Please check with your Regence account executive for eligibility*****

	Under 65 Health Plan	Over 65 PSR Preferred	Over 65 Regence Medicare Script (Part D)	Over 65 MedAdvantage + Rx Classic PPO Plan
Employee	❒	❒	❒	❒
Spouse	❒	❒	❒	❒
Dependent Coverage	❒	❒	❒	❒

❒ I hereby DECLINE coverage on the Public School Retiree Preferred plan and the group MedAdvantage + Rx Classic PPO plan offered through Regence BlueShield of Idaho. By declining coverage, I understand that I am no longer eligible to enroll on these group plans at a future date.

Payment Options:

❒ **PERSI Pay –** payment will automatically be taken from your PERSI sick leave account or monthly pension check each month.

PERSI sick leave account that premiums will be deducted from ❒ Person Retiring ❒ Spouse's Account

If having your premium deducted from your Spouse's PERSI sick leave account, please provide name on PERSI account:_____

❒ **Direct Pay –** we will bill you for your premium (select one) ❒ monthly ❒ quarterly

❒ **Deduct from your Bank Account –** a completed Bank Draft form is required (enclosed).

I authorize Regence BlueShield of Idaho and PERSI to exchange my address and enrollment information for purposes of administering this plan.

Retiree's Signature:_____ Date:_____

School District Official's Signature:_____ Date:_____

A Health plan with a Medicare contract
A Medicare-approved Part D sponsor

RETIREE LIFE INSURANCE REQUEST FORM

Emmett School District #221

PLEASE PRINT

Name of Retiree _____ ☐ Male ☐ Female

Social Security Number_____ Birthdate_____ Phone Number_____

Address _____

(City) (State) (Zip Code)

_____

Amount of Life Insurance (Choose One):
Terminates at age 75

☐ **$5,000 Monthly Premium: $17.50**
(Coverage amount of $20,000 or less prior to retirement)

☐ **$10,000 Monthly Premium: $35.10**
(Coverage amount of $30,000 or less prior to retirement)

☐ **$20,000 Monthly Premium: $70.20**
(Coverage amount of $30,001 - $50,000 prior to retirement)

☐ **$30,000 Monthly Premium: $105.30**
(Coverage amount of more than $50,000 prior to retirement)

Date of Retirement _____ Coverage Paid by District through _____

School Number and Address: Emmett School District #221 119 N Wardwell Ave Emmett, ID 83617

Signed-School District Office: _____

NOTE: Eligible Retirees must have Sick Leave Funds available through PERSI

Please pay my group life insurance premium in the total amount shown above until my sick leave entitlement is exhausted. Rates, benefits, and eligibility of continued coverage of retirees are subject to the terms of the Group Policy issued to the School District by United Heritage Life Insurance Company.

The premium is subject to change. If the premium changes, I authorize the deduction of the premium amount. After my sick leave entitlement has been exhausted, I request the Public Employee Retirement System of Idaho to continue my Life Insurance coverage by withholding the required premium from my retirement allowance until otherwise notified in writing. ☐ Yes ☐ No

☐ **I do not wish to continue coverage**

Beneficiary Designation (Please furnish name, relationship, and address) _____
(Beneficiary Name)

_____
(Beneficiary Relationship) (Beneficiary Address) (City) (State)(Zip Code)

Retiree Signature_____ Date_____

Approved by United Heritage Life Insurance Company:
Date_____ Signature _____

This form is to be completed and signed by the School District Official, signed by the Retiree, sent to United Heritage Life Insurance Company, PO Box 7777; Meridian, ID 83680, and forwarded by United Heritage to PERSI.

United Heritage Life Insurance Company
A United Heritage Financial Group Company
P.O. Box 7777, Meridian, ID 83680-7777 | (208) 493-6100 Toll Free (800) 657-6351 | unitedheritage.com

DELTA DENTAL

deltadentalid.com

Group Insurance Benefits Request
Idaho School Retirees

Retirees Name _____ Subscriber Number _____

Birth Date _____

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_____

School District's Address _____

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 ☐

Are you over the age of 65? Yes ☐ No ☐

Please pay the Delta Dental premium of $_____until my sick leave entitlement is exhausted. 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 Delta Dental.

Dependent Spouse's Name_____Birthdate_____

Dependent Child's Name and 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, 555 E. Parkcenter Blvd, Boise, ID, 83706 by the tenth of the month preceding retirement. Delta Dental of Idaho will send notification to the Public Employee Retirement System.

Statewide Schools Retiree Application

Requested Effective Date _____

❑ **Retiree Deferral Request**

SCHOOL DISTRICT INSTRUCTIONS: Please have the Retiree complete and sign this form, then complete your portion on the back. Have your participating school district or school related group official sign and return the form to Blue Cross of Idaho.

RETIREE INSTRUCTIONS: Please complete the information below and sign and date the back of the form.

Applicant Information *(Retiree)*

First Name	Last Name	Middle Initial	Marital Status	Gender
			❑ Single ❑ Married ❑ Divorced ❑ Widowed	❑ Male ❑ Female
Address	City, State, Zip Code	Phone Number		
Social Security Number	Blue Cross of Idaho Identification Number	Blue Cross of Idaho Group Number		
Medicare Beneficiary Number	Date of Retirement	Birthdate		

Dependent Information - Please include the following eligible dependents who are currently covered under my program and will continue to be covered under my Retiree Program. List all eligible dependents you wish to enroll, including any child who is under the age of 26; or who is medically certified as disabled and dependent on parent for support *(copy of certification required)*.

Dependent Spouse's Name	Spouse's Social Security Number	Medicare Beneficiary Number	Birthdate
Dependent Child's Name	Child's Social Security Number	Medicare Beneficiary Number	Birthdate
Dependent Child's Name	Child's Social Security Number	Medicare Beneficiary Number	Birthdate

Medical Coverage - Please choose appropriate coverage from the selections below.
Retiree enrollment may be equal to or lesser than active employee enrollment.

UNDER 65

	Health	Dental (if applicable)	Vision (if applicable)
Employee	❑ PPO ❑ HSA ❑ POS	❑ PPO Dental Plan ❑ Dental Blue Connect	☐
Spouse	❑ PPO ❑ HSA ❑ POS	❑ PPO Dental Plan ❑ Dental Blue Connect	☐
Child	❑ PPO ❑ HSA ❑ POS	❑ PPO Dental Plan ❑ Dental Blue Connect	☐
Child	❑ PPO ❑ HSA ❑ POS	❑ PPO Dental Plan ❑ Dental Blue Connect	☐

OVER 65

	Retiree Plan with RX	Retiree Plan without RX	Dental Coverage (if applicable)	Vision (if applicable)	**Medicare Supplement***	**Medicare Advantage****
Employee	☐	☐	❑ PPO Dental Plan ❑ Dental Blue Connect	☐	☐	☐
Spouse	☐	☐	❑ PPO Dental Plan ❑ Dental Blue Connect	☐	☐	☐

*** A Medicare Supplement enrollment form is required to enroll in Blue Cross of Idaho's Medicare Supplement plans. Call 1-888-GO CROSS (1-888-462-7677) toll free to request a form and plan information.**

****A Medicare Advantage enrollment form is required to enroll in Blue Cross of Idaho's Medicare Advantage plans. Call 1-888-492-2583 toll free to request a form and plan information.**

FOR OFFICE USE ONLY

Group Number	Subgroup	Effective Date	Plan ID			Class	Reason Code
			M	D	V		

Street Address: 3000 E. Pine Ave., Meridian, ID 83642-5995 • *Mailing Address:* P.O. Box 7408, Boise, ID 83707-1408 • (208) 345-4550

Form No. 4-150 (11-20)

Current/Prior Coverage
(For Coordination of Benefits, please complete the section below. Use extra paper if necessary).

Name	Name of Carrier	Policy Number	Type of Policy (Group or Individual)	Date of Policy		Will Current Policy Continue?
				Start Date (mm/dd/yy)	End Date (mm/dd/yy)	

Benefits offered to Retirees **under age 65**, under the Blue Cross of Idaho School Insurance Program, are to be the same benefits offered to active employees. If you had dental coverage through BCI while an active employee, you will be allowed to continue that dental coverage as a Retiree, as long as the group offers that benefit to its employees.

Retirees and/or spouses **over the age of 65** will be enrolled in our Blue Cross of Idaho School Insurance Over 65 Medicare Program and **must** be enrolled in Parts A and B. You are eligible for dental benefits if the participating school district or school related group you retired from participates in BCI's school program and you were enrolled in a dental plan through your participating school district or school related group for **12 months prior to enrolling in this retiree program.**

Please note that Blue Cross of Idaho cannot guarantee billing or payment of all policies selected by PERSI. If for any reason your premiums cannot be paid by PERSI, Blue Cross of Idaho will bill you directly.

RETIREE'S signature: _____ Date: _____

I authorize the Public Employee Retirement System of Idaho (PERSI) and Blue Cross of Idaho to exchange my address and enrollment information for the purpose of administering this plan.

RETIREE'S signature: _____ Date: _____

Sign for Deferment Only

I choose to defer my enrollment in the retiree program as well as my draw on unused sick leave entitlement with PERSI. I understand if I choose not to continue coverage at the time of retirement I may not be able to enroll at a later date. Later enrollment is possible only if your school district or school related group remains with Blue Cross of Idaho and you maintain continuous coverage. If your school district chooses another carrier, you will not be able to enroll in the program.

RETIREE'S signature: _____ Date: _____

TO BE COMPLETED BY THE PARTICIPATING SCHOOL DISTRICT OR SCHOOL RELATED GROUP:

Not necessary for currently enrolled retirees

Coverage paid by the Participating School District or School Related Group through the month of: _____, 20_____

_____

Signature of Participating School District or School Related Group Official

_____ _____

Name of Participating School Group or School Related Group *Group Number*

DISCRIMINATION IS AGAINST THE LAW

Blue Cross of Idaho and Blue Cross of Idaho Care Plus, Inc., (collectively referred to as Blue Cross of Idaho) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Blue Cross of Idaho does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Blue Cross of Idaho:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Blue Cross of Idaho Customer Service Department. Call 1-800-627-1188 (TTY: 711), or call the customer service phone number on the back of your card. If you believe that Blue Cross of Idaho has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with Blue Cross of Idaho's Grievances and Appeals Department at:

Manager, Grievances and Appeals
3000 E. Pine Ave., Meridian, ID 83642
Telephone: 1-800-274-4018
Fax: 208-331-7493
Email: ***grievances&appeals@bcidaho.com***
TTY: 711

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Grievances and Appeals team is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at ***https://ocrportal.hhs.gov/ocr/portal/lobby.jsf***, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TTY). Complaint forms are available at ***http://www.hhs.gov/ocr/office/file/index.html***.

ATTENTION: If you speak Arabic, Bantu, Chinese, Farsi, French, German, Japanese, Korean, Nepali, Romanian, Russian, Serbo-Croatian, Spanish, Tagalog, or Vietnamese, language assistance services, free of charge, are available to you. Call 1-800-627-1188 (TTY: 711).

Arabic انتبه: إذا كنت تتحدث اللغة العربية ، فإن خدمات المساعدة اللغوية متاحة لك مجانًا اتصل على 1-800-627-1188 (للصم والبكم: 711).

Bantu: ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-800-627-1188 (TTY: 711).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-627-1188 (TTY：711)。

Farsi توجه: اگر به زبان فارسی صحبت می کنید، خدمات رایگان پشتیبانی زبان، در دسترس شما است. شماره تماس 1-800-627-1188 (711:TTY).

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-627-1188 (ATS : 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-627-1188 (TTY: 711).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-627-1188（TTY:711）まで、お電話にてご連絡ください。

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-627-1188 (TTY: 711)번으로 전화해 주십시오.

Nepali: ध्यान दनुिहोस्: तपाईंले नेपाली बोलनुहुन्छ भने तपाईंको नमिति भाषा सहायता सेवाहरू नःिशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-627-1188 (टटिवाइ: 711) ।

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-627-1188 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-627-1188 (телетайп: 711).

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-627-1188 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-627-1188 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-627-1188 (TTY: 711.

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-627-1188 (TTY: 711).

UNDER 65 RETIREE VISION INSURANCE REQUEST FORM

PLEASE PRINT

Name of Retiree _____ ☐ Male ☐ Female

Social Security Number_____ Birthdate_____ Phone Number_____

Address _____

(City) (State) (Zip Code)

Vision Tier: ☐ Employee ($*7.83*), ☐ Employee + Spouse ($*15.69*), ☐ Employee + Children ($*16.78*), ☐ Employee + Family ($*26.81*)

Dependents Name	Relationship	Date of Birth	Gender

Total Monthly Premium: _____

Date of Retirement _____ Coverage Paid by District through _____

School Number and Address:

Signed-School District Office: _____

NOTE: Eligible Retirees must have Sick Leave Funds available through PERSI

Please pay my group vision insurance premium in the total amount shown above until my sick leave entitlement is exhausted. Rates, benefits, and eligibility of continued coverage of retirees are subject to the terms of the Group Policy issued to the School District by United Heritage Life Insurance Company.

The premium is subject to change. If the premium changes, I authorize the deduction of the premium amount.

☐ **I do not wish to continue coverage**

Retiree Signature_____ Date_____

Approved by United Heritage Life Insurance Company:

Date_____ Signature _____

This form is to be completed and signed by the School District Official, signed by the Retiree, sent to United Heritage Life Insurance Company, PO Box 7777; Meridian, ID 83680, and forwarded by United Heritage to PERSI.

65 & OVER RETIREE VISION INSURANCE REQUEST FORM

PLEASE PRINT

Name of Retiree _____ ☐ Male ☐ Female

Social Security Number_____ Birthdate_____ Phone Number_____

Address _____
(City) (State) (Zip Code)

Vision Tier: ☐ Employee ($*12.24*), ☐ Employee + Spouse ($*24.41*), ☐ Employee + Children ($*28.75*), ☐ Employee + Family ($*28.75*)

Dependents Name	Relationship	Date of Birth	Gender

Total Monthly Premium: _____

Date of Retirement _____ Coverage Paid by District through _____
School Number and Address:
Signed-School District Office: _____

NOTE: Eligible Retirees must have Sick Leave Funds available through PERSI

Please pay my group vision insurance premium in the total amount shown above until my sick leave entitlement is exhausted. Rates, benefits, and eligibility of continued coverage of retirees are subject to the terms of the Group Policy issued to the School District by United Heritage Life Insurance Company.

The premium is subject to change. If the premium changes, I authorize the deduction of the premium amount.

☐ **I do not wish to continue coverage**

Retiree Signature_____ Date_____

Approved by United Heritage Life Insurance Company:
Date_____ Signature _____

This form is to be completed and signed by the School District Official, signed by the Retiree, sent to United Heritage Life Insurance Company, PO Box 7777; Meridian, ID 83680, and forwarded by United Heritage to PERSI.

United Heritage Life Insurance Company
A United Heritage Financial Group Company
P.O. Box 7777, Meridian, ID 83680-7777 | (208) 493-6100 Toll Free (800) 657-6351 | unitedheritage.com