



Washoe County School District Retiree Enrollment

Last Name	First Name	MI	SSN	Employee # E000
Physical Address	City	State	Zip Code	Date of Birth Phone Number
Mailing Address (if different than Physical)	City	State	Zip Code	Email Address
Retirement Effective Date	Hire Date	Type of Employee: ☐ Certified ☐ ESP ☐ Administrator ☐ Confidential		

Medicare Information (if applicable)

Are you enrolled in Medicare? ☐ Yes ☐ No If yes, provide:

Medicare #: _____ Part A Effective Date: _____ Part B Effective Date: _____

If you are enrolling your Spouse into your coverage is your Spouse enrolled in Medicare? ☐ Yes ☐ No If yes, provide:

Medicare #: _____ Part A Effective Date: _____ Part B Effective Date: _____

Current Medical/Dental Coverage Plan Upon Retirement: ☐ Plan – PPO ☐ Plan – QHDHP

Coverage Election

Please select the benefits you would like to enroll in:

☐ Medical/Dental ☐ Vision ☐ Gap (plan PPO only) ☐ *Basic Life ☐ **Supplemental Life

Total Premium: _____

Dependent Information (if enrolling dependents)

Relationship	Last Name	First	MI	Date of Birth	Sex M/F	Dependent Social Security #	Email Address

*Basic Life Insurance \$40,000 Limit (Cert/ESP) \$50,000 Limit (Admin/Confidential) \$200,000 Limit (Administrator)

**The total combined limit of Basic Life and Additional Supplemental Life that may be combined is \$200,000.

The District may provide a retiree health insurance subsidy to eligible retirees. Eligibility is limited to Education Support Professional (ESP) employees hired prior to July 1, 1999 with at least 15 years of consecutive service at the time of retirement. Certified and Administrative employees are not eligible for this subsidy. The subsidy amount is subject to collective bargaining agreements and may change in the future.

Employee Certification:

With my signature, I hereby declare, certify and state under penalty of perjury that the information I have provided here is true and correct, that any dependents listed above are eligible under my Employer's Dependent Benefit Criteria. Further, I understand that the information supplied, herein, may be used by my Employer in order to verify my dependent(s) for purpose of coverage, to make decisions about my coverage under my Employer's employee benefit plans and as otherwise necessary in connection with managing the organization's employee benefits plans. Finally, I understand that if required documents have not been provided by my Employer's deadline, my non-verified dependents' coverage will be terminated.

I authorize WCSD to deduct the premiums indicated above from my PERS retirement check. I understand these premiums are subject to periodic changes. Therefore, I authorize WCSD to deduct these premium changes from my PERS retirement check as required. If premium is not deducted from PERS check, Retiree must notify and pay WCSD Health Insurance Fund directly by the 25th of the month. Failure to report any errors in premium to the Benefits Department could result in loss of premiums. A maximum of two (2) months of premiums will be reimbursed for overpayment due to non-notification.

Retiree Signature _____ Date Signed _____

Benefits Department Use Only		
Date Received: _____	Processed By: _____	Effective Date: _____