Retiree Health Enrollment

Selection and Deduction Agreement for Medical, Dental, Vision, Life and Dependent Coverage

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

SSN #: _____-- _____-- _____ Phone: _____ Email: _____

Address: _____

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. 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 at the Social Security Office.

Pension Plan: ☐ CalSTRS ☐ CalPERS

- **Medical Waiver** ☐ Waiver form and **proof of other group coverage attached**. ☐ OPT OUT
  * If eligible, the District/TPA will reimburse me based on my eligibility of 100% or 50%
- **Certificated Medical**
  Under 65. ☐ UHC ☐ Kaiser ☐ WHA
  Over 65: ☐ Anthem PPO ☐ Kaiser Senior Advantage
- **Classified/Mgmt Medical**
  Under 65: ☐ Kaiser ☐ Sutter Health ☐ Western Health
  Over 65: ☐ Kaiser Senior Advantage ☐ Health Compare/Futuris

☐ I elect Medical coverage
Retiree Only, Two-Party or Family (***circle one***)

- **Dental** ☐ I elect Dental coverage ☐ I do not elect **Dental** coverage
  Retiree Only, Two-Party or Family (*circle one*)
  Select plan: ☐ Delta Dental or ☐ Premier Access (SCTA only)
- **Vision** ☐ I elect Vision coverage ☐ I do not elect **Vision** coverage
  Retiree Only, Two-Party or Family (***circle one***)
- **Life** ☐ I elect Life Insurance coverage ☐ I do not elect **Life** coverage
  Retiree Only, Two-Party or Family (**circle one**)
- **Dependent Life** ☐ I elect Dependent Life coverage ☐ I do not elect **Dependent Life** coverage
  Two-Party or Family (***circle one***)

NAME OF DEPENDENT	SOCIAL SECURITY NO.	DOB	RELATIONSHIP

I understand that with the above selected coverages, I am financially responsible for the following amount: $_____

I understand that if my retirement has a date of 10/31/2025 or earlier, my STRS/PERS pension will be reduced by my selected health plan options. If my STRS/PERS pension **does not cover** the total amount, I will need to make additional payments to the District or District's agent. If my retirement date is 11/1/2025 or later, I understand that any premiums I am responsible for will be managed and serviced by the District's third party administrator. 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):