



## Executive Management Retiree Election Form (Non Medicare Eligible)

If you are eligible for District paid lifetime medical benefits, premiums will be paid accordingly.

**Benefit Year: October 1, 2023 – September 30, 2024**

Dependent Verification must be provided to the Human Resources Office at the time the enrollment form is submitted for any new dependent added during this enrollment period.

- ❖ Dependent Verification documents for adding spouse or domestic partner include; Filed Tax return showing joint filing.
- ❖ Dependent verification documents for children include: Birth Certificate, Adoption Paperwork or Document Granting Legal Guardianship by the court, up until age 18.

ACTION REQUESTED				
<input type="checkbox"/> Qualifying Life Event  <input type="checkbox"/> Open Enrollment	<b>Please Select a Qualifying Life Event</b>			
	<input type="checkbox"/> Marriage/Domestic Partner <input type="checkbox"/> Divorce <input type="checkbox"/> Birth/Adoption	<input type="checkbox"/> Death <input type="checkbox"/> Gain/loss Coverage <input type="checkbox"/> Retirement	<input type="checkbox"/> Other (specify):	
RETIREE INFORMATION				
Legal Last Name		Legal First Name		Middle Initial
Street Address		City	State	Zip
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Phone Number		
Birthdate (mm/dd/yyyy) / /		Email Address		Social Security Number - -
Date of Event		Effective Date		If surviving spouse, list retiree name
HEALTH BENEFIT PLANS SELECTION				

Benefit Plan Monthly Rates			
Medical Plan (Verify eligibility with Benefits Specialist)	Single-Party	Two-Party	Family
<b>HMO</b>			
Kaiser Permanente \$15 - 234480-0089RMN	<input type="checkbox"/> \$793.00	<input type="checkbox"/> \$1,586.00	<input type="checkbox"/> \$2,061.00
Blue Shield Trio - 701071H031002	<input type="checkbox"/> \$815.00	<input type="checkbox"/> \$1,622.00	<input type="checkbox"/> \$2,117.00
Blue Shield Full Network - 701071H011002	<input type="checkbox"/> \$849.00	<input type="checkbox"/> \$1,693.00	<input type="checkbox"/> \$2,209.00
<b>PPO</b>			
Blue Shield 80G – 701070P031002	<input type="checkbox"/> \$832.00	<input type="checkbox"/> \$1,658.00	<input type="checkbox"/> \$2,163.00
Blue Shield 90G - 701070P021002	<input type="checkbox"/> \$905.00	<input type="checkbox"/> \$1,806.00	<input type="checkbox"/> \$2,358.00
Blue Shield 100A - 701070P011002	<input type="checkbox"/> \$1,052.00	<input type="checkbox"/> \$2,110.00	<input type="checkbox"/> \$2,756.00
<b>Dental Plan (Retiree Paid Premiums) Failure to elect coverage at time of retirement will forfeit your eligibility for future enrollment.</b>			
Delta Care HMO - 71691 06012	<input type="checkbox"/> \$29.58	<input type="checkbox"/> \$52.22	<input type="checkbox"/> \$56.81
Delta Dental PPO Plan 1500; \$2,000 Orthodontics - 7079 3002	<input type="checkbox"/> \$54.60	<input type="checkbox"/> \$110.00	<input type="checkbox"/> \$158.20
Delta Dental PPO Plan Unlimited; \$2,000 Orthodontics - 7079 3003	<input type="checkbox"/> \$79.60	<input type="checkbox"/> \$160.00	<input type="checkbox"/> \$224.20
<b>Vision Plan (Retiree Paid Premiums) Failure to elect coverage at time of retirement will forfeit your eligibility for future enrollment.</b>			
VSP Signature Plan C, Single \$0 Copay - 2978582A	<input type="checkbox"/> \$14.30	<input type="checkbox"/> \$28.60	<input type="checkbox"/> \$42.90
<b>RETIREE PAID: Total Monthly Premium Amount</b>	<b>\$</b>		

Retiree Signature (Required) \_\_\_\_\_ Print Name \_\_\_\_\_ Date \_\_\_\_\_

RETURN COMPLETED FORM(S) via email at [hrbenefits@mtsac.edu](mailto:hrbenefits@mtsac.edu)

**Internal Human Resources Use Only:**  SISC  Banner  Log  Payroll Banner ID#: A \_\_\_\_\_

**Lifetime Medical Eligibility:**  Single Party  Two Party