



**Classified and Auxiliary Retiree Election Form (Non-Medicare Eligible)**

Classification:  CSEA 262                       CSEA 651                       Auxiliary

**Benefit Year: January 1, 2021 – September 30, 2022**

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"/> Death <input type="checkbox"/> Divorce <input type="checkbox"/> Gain/loss Coverage <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Retirement <input type="checkbox"/> Other (specify):

RETIREE INFORMATION				
Legal Last Name	Legal First Name	Middle Initial	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Street Address	City	State	Zip	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 - 233929-0009RLN	<input type="checkbox"/> \$688.00	<input type="checkbox"/> \$1,376.00	<input type="checkbox"/> \$1,789.00
Kaiser Permanente \$0 - 233929-0008RLN	<input type="checkbox"/> \$736.00	<input type="checkbox"/> \$1,472.00	<input type="checkbox"/> \$1,914.00
Blue Shield Trio - 701071H031003	<input type="checkbox"/> \$723.00	<input type="checkbox"/> \$1,433.00	<input type="checkbox"/> \$1,870.00
Blue Shield Full Network - 701071H011003	<input type="checkbox"/> \$752.00	<input type="checkbox"/> \$1,494.00	<input type="checkbox"/> \$1,950.00
<b>PPO</b>			
Blue Shield 90G - 701070P021003	<input type="checkbox"/> \$803.00	<input type="checkbox"/> \$1,599.00	<input type="checkbox"/> \$2,087.00
Blue Shield 100A - 701070P011003	<input type="checkbox"/> \$931.00	<input type="checkbox"/> \$1,863.00	<input type="checkbox"/> \$2,433.00
<b>Dental Plan (Retiree Paid Premiums)</b>			
Delta Care HMO - 71691 06010	<input type="checkbox"/> \$29.58	<input type="checkbox"/> \$52.22	<input type="checkbox"/> \$56.81
Delta Dental PPO Plan 1500; \$2,000 Orthodontics - 7079 3007	<input type="checkbox"/> \$58.60	<input type="checkbox"/> \$118.00	<input type="checkbox"/> \$169.20
Delta Dental PPO Plan Unlimited; \$2,000 Orthodontics - 7079 3008	<input type="checkbox"/> \$84.60	<input type="checkbox"/> \$170.00	<input type="checkbox"/> \$237.00
<b>Vision Plan (Retiree Paid Premiums)</b>			
VSP Signature Plan C, Single \$0 Copay - 2978579A	<input type="checkbox"/> \$15.60	<input type="checkbox"/> \$31.20	<input type="checkbox"/> \$46.80
<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