

Confidential and Management Retiree Election Form (Non Medicare Eligible)								
Classification:	☐ Confidential	☐ Management						

Benefit Year: October 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 REQUE	STED							
☐ Qualifying	Please Select a Qualifying Life Event										
Life Event □ Open Enrollment	☐ Marriage/Domest☐ Divorce☐ Birth/Adoption☐							$\square$ Other (specify):			
		RE	TIREE INFORM	ATION							
Legal Last Name			Legal First Name			Middle Initial					
Street Address	3		City State			Zip Phone Number					
Birthdate (mm/dd/yyyy) Email A			ress Soci			al Security Number					
Date of Event	Pate of Event Effective			Date If su			urviving spouse, list retiree name				
		HEALI	H BENEFII PLA	NS SELECTION							
					Benefit Plan Monthly Rates						
Medical Plan	(Verify eligibility with		Single-I	Party	Two-	Party	Family				
Kaiser Perman	□ ¢699	□ \$688.00		00	□ \$1,789.00						
Blue Shield Tri	□ \$723				□ \$1,789.00 □ \$1,870.00						
Blue Shield Ful	□ \$752	• • •			□ \$1,950.00						
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Blue Shield 80	□ \$741	□ \$741.00 □ \$1,47			□ \$1,918.00						
Blue Shield 90	□\$803	□\$803.00 □ \$1		99.00 🗆 \$2,087.00							
Blue Shield 100	□ \$931	□ \$931.00 □ \$			□ \$2,433.00						
Dental Plan (R	Retiree Paid Premium	s)									
Dental Plan (Retiree Paid Premiums)  Delta Care HMO - 71691 06012					□ \$29.58 □ \$52.			□ \$56.81			
Delta Dental P		□ \$58.60 □ \$3			□ \$169.20						
Delta Dental PPO Plan Unlimited; \$2,000 Orthodontics - 7079 3003					\$84.60 🗆 \$170.		0	□ \$237.20			
<b>Vision Plan</b> (R	etiree Paid Premiums	)									
VSP Signature Plan C, Single \$0 Copay - 2978582A					\$15.60 🗆 \$31.20		)	□ \$46.80			
ETIDEE DAID: 1	Total Monthly Premic	ım Amount		\$							
LTINLL FAID.	iotal Monthly Frening	im Amount		Р							
etiree Signature (Required) Print Name							Date	e			
		RETURN COMPLETED F	ORM(S) via ema	ail at <u>hrbenefits@</u>	mtsac	<u>.edu</u>					
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