



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	Please Select a Qualifying Life Event			
<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Marriage/Domestic Partner	<input type="checkbox"/> Death	<input type="checkbox"/> Other (specify):	
	<input type="checkbox"/> Divorce	<input type="checkbox"/> Gain/loss Coverage		
	<input type="checkbox"/> Birth/Adoption	<input type="checkbox"/> Retirement		
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
HMO			
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
PPO			
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
Dental Plan (Retiree Paid Premiums) Failure to elect coverage at time of retirement will forfeit your eligibility for future enrollment.			
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
Vision Plan (Retiree Paid Premiums) Failure to elect coverage at time of retirement will forfeit your eligibility for future enrollment.			
VSP Signature Plan C, Single \$0 Copay - 2978582A	<input type="checkbox"/> \$14.30	<input type="checkbox"/> \$28.60	<input type="checkbox"/> \$42.90
RETIREE PAID: Total Monthly Premium Amount	\$		

Retiree Signature (Required) _____ Print Name _____ Date _____

RETURN COMPLETED FORM(S) via email at hrbenefits@mtsac.edu

Internal Human Resources Use Only: SISC Banner Log Payroll Banner ID#: A _____

Lifetime Medical Eligibility: Single Party Two Party