



# 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, 2026 – September 30, 2027**

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<br><br><input type="checkbox"/> Open Enrollment | <input type="checkbox"/> Marriage/Domestic Partner<br><input type="checkbox"/> Divorce<br><input type="checkbox"/> Birth/Adoption | <input type="checkbox"/> Death<br><input type="checkbox"/> Gain/loss Coverage<br><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)<br>/ /  |   | Email Address  |   | Social Security Number<br>- -          |  |
| 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"/> \$975.00   | <input type="checkbox"/> \$1,951.00 | <input type="checkbox"/> \$2,536.00 |
| Blue Shield Trio - 701071H031002  | <input type="checkbox"/> \$998.00   | <input type="checkbox"/> \$1,987.00 | <input type="checkbox"/> \$2,595.00 |
| Blue Shield Full Network - 701071H011002  | <input type="checkbox"/> \$1,041.00 | <input type="checkbox"/> \$2,075.00 | <input type="checkbox"/> \$2,709.00 |
| <b>PPO</b>  |                                     |                                     |                                     |
| Blue Shield 80G – 701070P031002   | <input type="checkbox"/> \$1,020.00 | <input type="checkbox"/> \$2,031.00 | <input type="checkbox"/> \$2,652.00 |
| Blue Shield 90G - 701070P021002   | <input type="checkbox"/> \$1,108.00 | <input type="checkbox"/> \$2,214.00 | <input type="checkbox"/> \$2,892.00 |
| Blue Shield 100A - 701070P011002  | <input type="checkbox"/> \$1,290.00 | <input type="checkbox"/> \$2,588.00 | <input type="checkbox"/> \$3,382.00 |
| <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 - 252464824RMN   | <input type="checkbox"/> \$14.30    | <input type="checkbox"/> \$28.60    | <input type="checkbox"/> \$42.90    |
|   |                                     |                                     |                                     |
|   |                                     |                                     |                                     |

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