

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

Classification: ☐ CSEA 262

☐ CSEA 651

☐ Auxiliary

Benefit Year: October 1, 2025 – September 30, 2026

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

☐ **Qualifying Life Event**

☐ **Open Enrollment**
☐ Marriage/Domestic Partner
☐ Divorce
☐ Birth/Adoption

☐ Death
☐ Gain/loss Coverage
☐ Retirement

☐ 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

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

Benefit Plan Monthly Rates			
Medical Plan (Verify eligibility with Benefits Specialist)	Single-Party	Two-Party	Family
HMO			
Kaiser Permanente \$15 - 234480-0089RLN	<input type="checkbox"/> \$902.00	<input type="checkbox"/> \$1,805.00	<input type="checkbox"/> \$2,346.00
Kaiser Permanente \$0 - 234480-0088RLN	<input type="checkbox"/> \$965.00	<input type="checkbox"/> \$1,931.00	<input type="checkbox"/> \$2,510.00
Blue Shield Trio - 701071H031003	<input type="checkbox"/> \$917.00	<input type="checkbox"/> \$1,825.00	<input type="checkbox"/> \$2,382.00
Blue Shield Full Network - 701071H011003	<input type="checkbox"/> \$955.00	<input type="checkbox"/> \$1,904.00	<input type="checkbox"/> \$2,486.00
PPO			
Blue Shield 90G - 701070P021003	<input type="checkbox"/> \$1,018.00	<input type="checkbox"/> \$2,034.00	<input type="checkbox"/> \$2,656.00
Blue Shield 100A - 701070P011003	<input type="checkbox"/> \$1,185.00	<input type="checkbox"/> \$2,377.00	<input type="checkbox"/> \$3,106.00
Dental Plan (Retiree Paid Premiums) Failure to elect coverage at time of retirement will forfeit your eligibility for future enrollment.			
Delta Care HMO - 71691 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"/> \$54.60	<input type="checkbox"/> \$110.00	<input type="checkbox"/> \$158.20
Delta Dental PPO Plan Unlimited; \$2,000 Orthodontics - 7079 3008	<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 - 252464824RLN	<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

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

Lifetime Medical Eligibility: ☐ Single Party ☐ Two Party