

County of Imperial - Retiree Enrollment Form

Retiree Information				
Last Name	First Name	Social Security Number	Date of Birth	
Home Address	City	State	Zip Code	Phone Number
Emergency Contact Information Name and Address				Phone Number

Medical Coverage - *Plan Requirements for Medicare Eligible <input type="checkbox"/> <u>Waive Medical Coverage</u>	
<input type="checkbox"/> Plan I/500 Deductible <input type="checkbox"/> Plan II /1500 Deductible <input type="checkbox"/> United Health Care Medicare # _____	<input type="checkbox"/> Retiree Only <input type="checkbox"/> Retiree + Spouse/Dependent <input type="checkbox"/> Survivor
Dental Coverage <input type="checkbox"/> <u>Waive Dental Coverage</u>	
<input type="checkbox"/> Principal (PPO Plan) <input type="checkbox"/> Dental Health Services (HMO)	<input type="checkbox"/> Retiree Only <input type="checkbox"/> Retiree + Spouse/Dependent <input type="checkbox"/> Survivor
Vision Coverage <input type="checkbox"/> <u>Waive Vision Coverage</u>	
<input type="checkbox"/> VSP	<input type="checkbox"/> Retiree Only <input type="checkbox"/> Retiree + Spouse/Dependent <input type="checkbox"/> Survivor

Dependent Information					
Spouse Last Name	First Name	SS Number	Date of Birth	Gender	Phone Number
Dependent Last Name	First Name	SS Number	Date of Birth	Gender	Phone Number
Dependent Last Name	First Name	SS Number	Date of Birth	Gender	Phone Number

Legally married or registered domestic partner in the state of California.
 Natural born children, stepchildren and/or those awarded by court order up to age 26.

Acknowledgment
<p>I agree: All information on this form is correct and true to the best of my knowledge and belief. I wish to be enrolled in all plans as indicated and authorize County of Imperial to deduct from my earnings the contribution (if any) required toward the cost of this plan. *Medicare Coverage: At age 65, eligible retirees will be required to enroll in Medicare Part A and B coverage and participate in the County's Medicare Supplemental Plan. Failure to comply can result in loss of coverage. I authorize the release of any medical or other information necessary to process this claim. I understand that if I have misrepresented or omitted any material fact that my coverage may be cancelled.</p> <p>The above selection can <u>only</u> be changed within 31 calendar days of a Qualifying Event, with written request and proof or until Open Enrollment. <u>Qualifying Event Includes:</u> marriage, newborn, divorce, loss of previous coverage, Medicare entitlement; etc. I, the applicant, acknowledge that I have read and understood this Application in its entirety.</p>
<p>Signature: _____ Date: _____</p>

Employer Use Only			
Date of Hire:	Date of Retirement:	Effective Date :	Stamped Received
			<div style="border: 1px solid black; width: 100px; height: 100px; margin: auto;"></div>
Remarks:			