County of Imperial - Retiree Enrollment Form

Retiree Information	Retiree Email:		
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	□ **Waive Medical Coverage**
□ Plan I/500 Deductible	□ Retiree Only
□ Plan II /1500 Deductible	□ Retiree + Spouse/Dependent
□ Anthem Medicare #_____	□ Survivor
Dental Coverage	□ **Waive Dental Coverage**
□ Principal (PPO Plan)	□ Retiree Only
□ Dental Health Services (HMO)	□ Retiree + Spouse/Dependent
	□ Survivor
Vision Coverage	□ **Waive Vision Coverage**
□ VSP	□ Retiree Only
	□ Retiree + Spouse/Dependent
	□ 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

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.

The above selection can only be changed within 31 calendar days of a Qualifying Event, with written request and proof or until Open Enrollment. Qualifying Event Includes: 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.**

Signature: Date:

Employer Use Only

Date of Hire:	**Date of Retirement:**	**Effective Date :**	Stamped Received
Remarks:			