



CLASSIFIED, MANAGEMENT & CLASS. CONFIDENTIAL

Retiree Groups 65+ w/ Medicare A & B**

ALL persons enrolled are 65+ with Medicare Parts A & B

Medical Plan Election Form

INSTRUCTIONS:

Plan changes are only allowed during the regular Open Enrollment period effective October 1 unless you have a mid-year qualifying event and notify the Benefits Office within 31-days of the qualifying event.

Review the plan options available, elect your plan by initialing the box below the plan you are electing then sign and date.
Forms are due to Human Resources Benefits Office as soon as possible in order to be processed in a timely manner.

RETIREE AGE 65+ with MEDICARE PARTS A & B
 (The rates below are applicable if all persons enrolled have Medicare Parts A & B)

SISC Pool Plans	Anthem PPO 100-A \$0, Rx 0-20 EGWP	Anthem PPO 100-A \$0, Rx 0-25 EGWP	Kaiser HMO* Trad HMO \$10, Rx 10
Single Rate	\$555	\$543	\$193
Two-Party Rate	\$1,110	\$1,086	\$386
Family Rate	\$1,450	\$1,423	N/A
KCCD Contribution	\$1,577.44	\$1,577.44	\$1,577.44

Retiree 65+ Cost Above District Contribution

Single Rate- cost to retiree (on Medicare) \$0

Two-Party Rate - cost to retiree (both Medicare) \$0

Family Rate - cost to retiree (ALL ON MEDICARE) \$0

Click box below for the rate that applies to you:

\$0 \$0 \$0

\$0 \$0 \$0

\$0 \$0 N/A

Click box below to select which retiree 65+ classification group applies to you: (ALL must be 65+ w/Medicare A&B)

Classified Retiree 65+ Group

Management Retiree 65+ Group

Retiree 65+ Medical Election Initial Box for Elected Plan

<input type="text"/>	<input type="text"/>	<input type="text"/>
4R001A-63537L	4R002G-63537L	225543-0311
<input type="text"/>	<input type="text"/>	<input type="text"/>
4R001A-63537M	4R002G-63537M	225543-0311

**** If enrolled in Medicare Parts A & B, you will automatically enroll in Medicare Part D**

* Kaiser Enrollees must live or work in Kaiser Service Area to be eligible to enroll. You must submit a Kaiser Enrollment Form with this Election Form

Note: Premium payment for enrollment in coverages above are due by the 1st of each month of coverage

PRINT FULL LEGAL NAME	SIGNATURE	DATE
ADDRESS (Include: City, State & Zip code)	PHONE NUMBER	
RETIREE SOCIAL SECURITY NUMBER	RETIREE EMAIL ADDRESS (Optional)	

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