Self Paid Faculty Retiree Group 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 AND DEPENDENTS UNDER AGE 65

(At least one person enrolled is under age 65. Enrollees over age 65 must have Medicare Parts A & B but will remain on the under 65 group enrollment)

SISC Pool Plans	Anthem PPO 100-A $20, Rx 5-20	Anthem PPO 90-G $20, Rx 7-25	Anthem PPO 80-G $30, Rx 7-25	Kaiser HMO* Trad HMO $10, Rx 10
Monthly Composite Rate (12)	$1,631	$1,427	$1,305	$1,286
Click box below to make selection:	Early Retiree Medical Election - Initial Elected Plan			
☐ Faculty Early Retiree Group Number	☐ 40818M	☐ 40818Q	☐ 40818Y	☐ 225543-3037

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-G $20, Rx 0-25 EGWP	Kaiser HMO* Kaiser Senior Advantage
Click on box below for tier rate that applies to you:			
☐ Single Rate- cost to retiree (on Medicare)	☐ $586	☐ $558	☐ $220
☐ Two-Party Rate - cost to retiree (both Medicare)	☐ $1,172	☐ $1,116	☐ $440
☐ Family Rate - cost to retiree (ALL ON MEDICARE)	☐ $1,529	☐ $1,455	
Click box below to make selection: (ALL must be 65+ w/Medicare A&B)	Retiree 65+ with Medicare A&B Medical Election Initial Elected Plan		
☐ Faculty Retiree 65+ Group	☐ 4R001A-63537C	☐ 4R002G-63537C	☐ 225543-0311

*Enrollees must live in Kaiser Senior Advantage Service Area and complete a Kaiser Enrollment Form and a Kaiser Plan Election Form to assign Medicare to Kaiser

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 _____

RETIREE SOCIAL SECURITY NUMBER _____ RETIREE EMAIL ADDRESS (Optional) _____

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