

Benefit Enrollment/Change Form 2026 Plan Year – Retired

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|---|--|
| <input type="checkbox"/> New Enrollment | <input type="checkbox"/> Annual Enrollment |
| <input type="checkbox"/> Reinstatement | <input type="checkbox"/> Change Enrollment |
| <input type="checkbox"/> Rehire | <input type="checkbox"/> Decline Coverage |

1: Employee Demographic Information

Employee Name (Last):	(First):	(MI):	Social Security Number (SSN):	Employer Group #: E50
Street Address:				Department:
City:			State:	Zip:
Phone #:		Email Address:		Status:
				<input type="checkbox"/> Active <input checked="" type="checkbox"/> Retired
Sex:			Date of Birth:	
<input type="checkbox"/> Male <input type="checkbox"/> Female				
Marital Status:			Date of Hire:	
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow <input type="checkbox"/> Separated				
			Date of Retirement:	

2: Type of Enrollment (select one option)

<input type="checkbox"/> New Enrollee	<input type="checkbox"/> Change in Coverage (QLE or OE ONLY)	<input type="checkbox"/> Termination of Coverage
Effective Date	Effective Date	Effective Date
Select Coverage Type: <input type="checkbox"/> Single (Retiree ONLY) <input type="checkbox"/> 2-Party (Retiree + one dependent) <input type="checkbox"/> Family (Retiree + two or more dependents) <input type="checkbox"/> Waive Offer of Coverage <i>Note: Coverage takes effect at 12:01 a.m. on the first day of eligibility.</i>	Select New Coverage Type: <input type="checkbox"/> Single (Retiree ONLY) <input type="checkbox"/> 2-Party (Retiree + one dependent) <input type="checkbox"/> Family (Retiree + two or more dependents) Reason for Change: <input type="checkbox"/> Marriage <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Loss of Other Coverage <input type="checkbox"/> Employment Status Change <input type="checkbox"/> Other _____ <i>Note: Coverage begins the date of the qualifying life event (QLE). *Enrollment forms must be submitted within 31 days of QLE with supporting documentation to add/change coverage due to event.</i>	Reason for Termination: <input type="checkbox"/> Acquired Coverage Elsewhere <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Retirement <input type="checkbox"/> Other _____ <i>Note: Coverage is good through the eve of the life event date and ceases at 12:01 a.m. on the date of the life event.</i>

Note: See costs associated with Coverage Types in section 3: below

3: Benefit Plan Selection (select one option)

The retiree will pay premiums for the coverage elected each month, which will be **withheld directly from your KCERA pension check**. **Please note that these rates do not factor in the monthly stipend or the amount you may be eligible to receive with the Retiree Health Supplement Program.**

- Medical/Rx/Dental (full coverage)
(Single: \$ 1,296.72 + Dental: \$ 48.52 = \$1,345.24); (2-Party: \$ 2,489.86 + Dental \$ 88.41 = \$2,578.27); (Family: \$ 3,366.21 + Dental \$128.30 = \$3,494.51)
- Dental ONLY
(Single: \$ 48.52); (2-Party: \$ 88.41); (Family: \$ 128.30)
- Medical/Rx ONLY
(Single: \$ 1,296.72); (2-Party: \$ 2,489.86); (Family: \$ 3,366.21)

Note: The Court does not allow split enrollment, so the coverage you elect for yourself requires that all dependents enrolled have the same exact coverage.

4: Dependent Information (List only those dependents to be added or removed from coverage)

<u>Action Type:</u>	<u>Dependent Type:</u>	<u>Last Name:</u>	<u>First Name:</u>	<u>MI</u>	<u>Date of Birth:</u>	<u>Sex:</u>	<u>Social Security Number (SSN) & Disability Status:</u>
<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner					<input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled: Y N
<input type="checkbox"/> Add <input type="checkbox"/> Remove	Child:					<input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled: Y N
<input type="checkbox"/> Add <input type="checkbox"/> Remove	Child:					<input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled: Y N
<input type="checkbox"/> Add <input type="checkbox"/> Remove	Child:					<input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled: Y N
<input type="checkbox"/> Add <input type="checkbox"/> Remove	Child:					<input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled: Y N
<input type="checkbox"/> Add <input type="checkbox"/> Remove	Child:					<input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled: Y N
<input type="checkbox"/> Add <input type="checkbox"/> Remove	Child:					<input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled: Y N

5: Proof of Coverage (attach to this form)

The Plan requires and reserves the right to request a copy of the following documentation* at any time for each dependent listed above in section 4.

Spouse – Marriage Certificate

Domestic Partner - Certificate of Domestic Partnership registered with the Secretary of State

Child(ren) - Birth Certificate, Adoption Papers and/or Legal documentation from the Court showing proof of relation

**and/or any additional information necessary to verify coverage eligibility*

6: Other Insurance / Coordination of Benefits Information

Are you covered under any other group/individual health plan, including Medicare? YES NO

Are any of the dependents you listed in section 4: covered by another group/individual health plan, including Medicare? YES NO

If yes, please complete below details of other coverage. Otherwise, if you answered NO, please skip to section 7 of this form.

Name of Policy holder:	Date of Birth of Policy holder:
Social Security Number of Policy holder:	Relationship to Policy holder:
Type of Coverage: <small>(M-Medical; Rx-Prescription; D-Dental; V-Vision)</small>	Effective Date: End Date:
Sponsoring Employer Name: <small>(if applicable)</small>	Insurance Carrier Name:
Member ID or Medicare #:	Policy Type: <small>(IND-Individual; GRP-Group plan; HMO-Health Maintenance Organization; MED-Medicare)</small>

Person(s) covered under above policy:

(List all dependents (including self) if covered under the Court's health plan(s) and the other plan listed directly above).

7: Coverage Declination

To be completed if any coverage is declined or refused by an eligible employee and / or their eligible family members;

HEALTH PLAN COVERAGE (CHECK IF DECLINED)

I decline coverage for:

- Myself Children
 Spouse Spouse and Children

REASON FOR DECLINING HEALTH COVERAGE (CHECK IF DECLINED)

- Covered by spouse's group coverage Medicare
 Spouse covered by employer's group coverage
 Other(explain)_____

I acknowledge that the available coverages have been explained to me by my employer, and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage, and I have decided not to enroll myself and/or my dependent(s), if any. I have made this decision voluntarily.

If declining coverage for you /dependent please sign here.

Date

8: Application & Authorization

I hereby request the amount of coverage for which I may become eligible under the group employee benefits plan and authorize deductions from my earnings (if any) required to cover my share of the premium.

Signature: _____ Date: _____