

Retiree Health Enrollment

Selection and Deduction Agreement for Dental/Vision/Life/Dependent Coverage

Name (PRINT): _____ Date of Birth: _____
(Last) (First)

S S #: _____ -- _____ -- _____ Phone: _____ Email: _____

Address: _____
(Street) (City and State) (Zip)

I want to change my current benefits as indicated below. Please enroll in one of the following retirement benefits. Refer to current rate sheet for premiums.

Pension Plan	STRS	PERS		
Medical Waiver	Waiver form and proof of other group coverage	attached.	OPT OUT	
Certificated	Health Net	Health Net	Seniortate7341 0 TdDEMC	1 Tc 0 Tw 94 0 0 <004