Retiree Health Benefits Change Form

Complete and return to: Employee Benefits, PVSD, 600 Temple Ave., Camarillo, CA 93010

A. RETIREE INFORMATION

Name: Last Name, First Name MI	Address: City, State, Zip Code:
Home Phone #: Change of: □ Address □ Phone □ Name □ Other: _____	Social Security #: XXX-XX-__ __ __ __ Email Address: _____

B. REASON FOR CHANGE

Effective Date of Change: _____

NOTE: Open Enrollment changes are effective on October 1st.

Disenrollment request requires a 45 calendar day advance notice. NO Exceptions

Reason for Change/Cancellation:

□ New Retiree
□ Open Enrollment
□ Death of Dependent (attach copy of Death Certificate)
□ Spouse is eligible for Medicare (attach copy of Medicare card)
□ Retiree is eligible for Medicare (attach copy of Medicare card)
□ Spouse/Dependent gained other insurance
□ Retiree gained other insurance
□ Other: _____

C. MEDICAL PLAN CHANGES

Do you wish to change medical plans? □ Yes □ No

NOTE: You may only change medical plans upon retirement, relocation from current service area, or during Open Enrollment

If yes, **NEW MEDICAL PLAN:**

Group Plans: □ Anthem PPO 90-A/$20 Co-Pay □ Anthem PPO 80-G/$20 Co-Pay □ Anthem PPO 80-L/$30 Co-Pay
□ Anthem PPO 80-M/$40 Co-Pay □ HMO Anthem Blue Cross □ HMO Kaiser

***Individual Plan:** □ *Anthem CompanionCare – Medicare Supplement

*If you enroll in an individual plan, you must submit your application along with a copy of your Medicare Card 45 days prior to the first of the month you want the change to be made.

List yourself and all eligible dependents and whether you wish to cancel coverage or remain enrolled for each person.

RELATIONSHIP Self, Spouse, Daughter/Son	LAST NAME, FIRST NAME MI	BIRTH DATE MM/DD/YYYY	C = CANCEL COVERAGE RE = REMAIN ENROLLED		
			Medical	Dental	Vision
SELF					

D. IMPORTANT! READ CAREFULLY

If you and your dependents are not enrolled in health, dental and/or vision coverage at the time of your retirement, you and your dependents may not enroll in health, dental and/or vision at any subsequent date. If you decline PVSD group coverage, you may enroll in one of the SISC Individual Retiree Plans (ie, CompanionCare) if offered by PVSD. ***Disenrollment request requires a 45 calendar day advance notice. NO Exceptions***

Contact the Employee Benefits Specialist at (805) 445-8605 or jalexander@pvsd.k12.ca.us if you have questions or need assistance in determining benefit and premium amounts.

I agree to pay health premiums in accordance with the invoice provided to me, if applicable. I understand that failing to pay premiums by the 10th of the month will result in cancellation of insurance coverage and will not be able to enroll in district coverage at any subsequent date. I have read and understand all information presented above.

Signature: _____ Date: _____

******For Benefits Use Only******

Rec _____ By_____HW____Med____ Dent____Vis____ Ret Spdsheet____ Inv # _____ PY____