City of Glendale

RETIREMENT HEALTH COVERAGE ELECTION FORM

MUST FILE BEFORE RETIREMENT DATE

Please Note: Retirees will retire with the plan option in which they belong to at the time of retirement. Retirees may change their plan option during the City's open enrollment period only. At Age 65 retirees must enroll in Medicare Part A and Part B as a condition of remaining in the City's medical plan. All retirees should contact the Social Security office at least three months before their 65th birthday. *It's important that all retirees keep the City of Glendale Human Resources Department informed of any address or dependent changes.*

SECTION 1: Retired Employee Information

Name of Retiree: | Employee ID: | Last Date Worked:

Address:

Phone#: | Date of Birth: | Email Address:

SECTION 2: Retired Employee's Bargaining Unit

☐ COUNCIL ☐ EXEC ☐ IBEW ☐ GCEA ☐ GFFA ☐ GMA ☐ GPOA

SECTION 3: Retirement Health Coverage Election

☐ WAIVER OF RETIREMENT HEALTH COVERAGE

☐All Applicable Coverage ☐Medical Only ☐Dental Only ☐Vision Only ☐Enrolled Under Spouse's Coverage

I, the undersigned, a qualified retired employee of the City of Glendale hereby certify that I have been given the opportunity to continue, at my expense, group insurance benefits for myself and dependent(s) as offered by said employer and, after careful consideration, have decided not to accept this offer on the above checked item. **I further understand that once I am off any of the City plans (Medical, Dental, Vision and/or Life) for any reason, I will not be able to return to the plan.**

_____ _____

Signature of Retiree Date

☐ RETIREMENT MEDICAL COVERAGE ELECTION

I, the undersigned, a qualified retired employee of the City of Glendale, wish to continue the medical coverage for dependents(s) and myself and do hereby agree to remit the required premium timely every month. I understand that my medical insurance will be terminated if I do not pay my medical premiums by the 1st of each month. **I further understand that once I am off the City plan, for any reason, I will not be able to return to the plan.**

Medical Coverage:

☐BC - Prudent Buyer (PPO) ☐BC – CaliforniaCare (HMO) ☐Kaiser Permanente (HMO) ☐Kaiser Permanente (DHMO)

Dependent Information:

Name of Dependent		Date of Birth	
Name of Dependent		Date of Birth	
Name of Dependent		Date of Birth	

Medical Calculation

Monthly Premium: $_____

Month First Premium Applies _____

Signature: _____ _____

Retiree Date

☐ RETIREMENT DENTAL COVERAGE ELECTION

I, the undersigned, a qualified retired employee of the City of Glendale, wish to continue the medical coverage for dependents(s) and myself and do hereby agree to remit the required premium timely every month. I understand that my dental insurance will be terminated if I do not pay my medical premiums by the 1st of each month. **I further understand that once I am off the City plan, for any reason, I will not be able to return to the plan.**

Guardian Dental Coverage:

☐High Option PPO ☐Buy-Up PPO ☐MDC-G90 DMO

Dependent Information:

Name of Dependent		Date of Birth	
Name of Dependent		Date of Birth	
Name of Dependent		Date of Birth	

Dental Calculation

Monthly Premium: $_____

Month First Premium Applies _____

Signature: _____ _____

Retiree Date

City of Glendale

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☐ RETIREMENT VOLUNTARY VISION COVERAGE ELECTION

I, the undersigned, a qualified retired employee of the City of Glendale, wish to continue the medical coverage for dependents(s) and myself and do hereby agree to remit the required premium timely every month. I understand that my medical insurance will be terminated if I do not pay my medical premiums by the 1st of each month. **I further understand that once I am off the City plan, for any reason, I will not be able to return to the plan.**

VSP Vision Coverage:
Retiree VSP Coverage

Dependent Information:

Name of Dependent		Date of Birth	
Name of Dependent		Date of Birth	
Name of Dependent		Date of Birth	

Vision Calculation

Monthly Premium: $_____

Month First
Premium Applies _____

Signature: _____ _____
Retiree Date