STAFF USE ONLY: Date Received _____
DO Notified ___ Enter QB ___ Enter BB ___
EH: AP ___

EGBERT
RETIREE HEALTH BENEFITS ENROLLMENT FORM
2027

Effective Date: / / 27

☐ New Retiree Retirement Date: / / ☐ Open Enrollment ☐ Other:

RETIREE INFORMATION

LAST NAME	FIRST NAME	MI	LAST 4 SSN#	BIRTH DATE / /

SPOUSE/PARTNER

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY #	BIRTH DATE / /	GENDER ___ M ___ F

Is your spouse/partner one of the following?

___ Active EGUSD Employee
___ EGBERT Retiree
___ EGUSD Retiree (Retired prior to 07/01/00)

A = ADD D=DELETE	DEPENDENTS TO ENROLL (More dependents? Ask office for Additional Dependent Form)			
	SPOUSE/PARTNER ABOVE? ___ YES ___ NO	☐ MEDICAL	☐ DENTAL	☐ VISION
	ADDITIONAL DEPENDENT – FULL NAME	☐ MEDICAL	☐ DENTAL	☐ VISION

ADDITIONAL DEPENDENT INFORMATION

DEPENDENT TYPE:	SOCIAL SECURITY #	BIRTH DATE / /	GENDER ___ M ___ F

SELECTED PLAN OPTIONS Contact EGBERT for Family/Survivor Plans		RETIREE MONTHLY PREMIUM (EGBERT STAFF TO COMPLETE) EGBERT subsidy for CSEA members retired on/after 7/1/10 is for Retiree Only				
PLAN	GROUP #	RETIREE ONLY Non-Medicare	RETIREE ONLY Medicare	RETIREE + 1 Non-Medicare	RETIREE + 1 1 Non-MC/1 MC	RETIREE + 1 Medicare
RETIREE CONTRIBUTION **Applies to ALL Non-Medicare Plan Options**		$202.90	$0.00	$405.80	$202.90	$0.00
KAISER						
Non-Medicare HMO	606592-2/3	$526.09		$1,052.01		
Senior Advantage HIGH	606592-2		$0.00		$480.23	$0.00
Senior Advantage LOW	606592-3		$0.00		$383.61	$0.00
KaiserNW (OR/WA) Non-MC		$223.99		$447.81		
KaiserNW (OR/WA) Senior Adv			$61.98		$240.11	$123.96
NON-KAISER						
Non-Medicare Only Sutter Health Plan Western Health Advantage	 171802-000004 108397-A002	 $659.65 $0.00		 $1,318.85 $0.00		
Medicare Only Anthem MA PPO	MA:CA069GRS PDP:CA029GRX		$45.86			$91.72
1 Non-Medicare/1 Medicare Sutter Health Plan + Anthem MA PPO Western Health Advantage + Anthem MA PPO					$659.65 $0.00	
ALTERNATIVE MEDICAL COVERAGE						
Private Pay Reimbursement	Monthly Max.	$964.00	$356.12	$1,928.16	$1,369.95	$712.24
Medical Waiver Reimbursement	Annual Amount	Non-Medicare $780		Medicare $390		
DENTAL & VISION						
Delta Dental	23556-00117					
Vision Service Plan	40164338-0001					
TOTAL MONTHLY AMOUNT:						

Retiree Signature: _____ **Date:** _____