

Retiree Benefits Enrollment Form (Monthly)

2023 Plan Year

Employee #:	Effective Date:
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Event/Employer Information

Event:

- ☐ New Retiree ☐ Family Status Change ☐ Beneficiary Change ☐ Medicare Eligible ☐ Terminating Child Aged 26
☐ Termination ☐ Open Enrollment ☐ Address Change ☐ Name Change

Retiree Information

Social Security #:	Last Name:	First Name:	Middle Initial:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth:
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Street Address:	Apt #:	City:	State:	ZIP Code:
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Home Phone: ()	Cell Phone: ()	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	FRS Plan: <input type="checkbox"/> Investment <input type="checkbox"/> Pension <input type="checkbox"/> Self-Pay/Pension
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Basic Life Insurance:

Name of Beneficiary:	Relationship:	%:	Life Amount:	Premium:
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Name of Contingent	Relationship:	%:
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Terminate Life Insurance ☐ Terminate Medical Insurance ☐ Terminate Dental Insurance ☐ Terminate Vision Insurance ☐

I acknowledge that if I terminate medical, dental, vision, or life insurance coverage, I will not be able re-enroll in my lifetime.

Signature: _____

Please place an "X" next to the desired elections and circle your premium for Medical, Dental, and Vision Coverage.

Medical	Plan 1 (5770) STANDARD <input type="checkbox"/>			Plan 2 (3769) BUY UP <input type="checkbox"/>			Blue Options Grp Medicare <input type="checkbox"/>
	Category 1	Category 2	Category 3	Category1	Category2	Category3	
Single <input type="checkbox"/>	\$511.59	\$577.01	\$511.59	\$605.85	\$624.59	\$605.85	\$341.23
Family <input type="checkbox"/>	\$965.94 \$1,227.81 \$852.82	\$1,313.82	\$965.94 \$1,227.81 \$1,313.82 \$918.24	\$1,197.77 \$1,434.24 \$947.08	\$1,478.60	\$1,197.77 \$1,434.24 \$1,478.60 \$965.82	\$682.46

Medicare Effective Date: _____ Part A: _____ Part B: _____

Dental	Dental Plan 1 <input type="checkbox"/>				Dental Plan 2 <input type="checkbox"/>		
		Category 1	Category 2	Category 3	Category 1	Category 2	Category 3
Single <input type="checkbox"/>	<input type="checkbox"/>	\$0.00	\$25.14	\$25.14	\$13.91	\$38.24	\$38.24
Family <input type="checkbox"/>	<input type="checkbox"/>	\$21.16	\$46.19	\$46.19	\$34.20	\$61.29	\$61.29

Vision	Election <input type="checkbox"/>	Category 1	Category 2	Category 3
	Single <input type="checkbox"/>	\$0.00	\$8.29	\$8.29
	Family <input type="checkbox"/>	\$13.28	\$21.28	\$21.28

Administration Use Only:	
Code 315:	Code 316:

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Dependent Information:					Election (E, C, T) E = Enroll C = Continue T = Term		
Name (Last, First, MI)	Relation	Social Security #	Gender	DOB	Medical	Dental	Vision
	Spouse						
	Child						
	Child						

Dependent Eligibility Documents

If you are enrolling new dependents, attach the following documents:

For Spouse:

*A Certified copy of your Marriage Certificate **AND one of the following:**

*A copy of the front page of your 2021 federal tax return confirming this dependent is your spouse OR a document **dated within the last 60 days** such as a recurring monthly household bill.

The document must list your spouse's name, the date, and your mailing address.

For Children up to age 26:

*A copy of the child's birth certificate or adoption certificate naming you or your spouse as the child's parent. If you are covering a stepchild and your spouse is not a covered dependent, you must also provide documentation of your current relationship to your spouse as requested above.

For Children with Disabilities aged 26 or older:

* A copy of the child's birth certificate (or hospital birth record) AND Evidence of Social Security Disability (SSD) showing parent/guardian and dependent names.

Spousal Surcharge \$55.42 per month ☐ YES ☐ NO

Qualifying Events & Benefit Election Changes

As stated in the St. Johns County School District Employee Medical, Dental, and Vision Plans, I can only Add, Change, or Delete my medical, dental, or vision coverage during open enrollment, unless I experience a Family Status Change during the Plan year and meet and complete the following requirements:

1. Family Status change will be the loss of health coverage due to the death of a spouse, termination of spouse's employment, divorce, or disability of a spouse. Other qualifying events are marriage, birth, dependent satisfies or ceases to satisfy requirements for coverage, adoption, or placement for adoption, etc.
2. Qualifying events must be reported to the Human Resources Benefits Department within 30 days from the date of the event. Any changes submitted after the 30-day time period will not be approved.

Preferred Method of Communication:

- ☐ Email _____
- ☐ Postal Mail (see address on front page)

X _____
Signature or legal representative signature

Date: _____

Administration Use Only:					
Email FRS:	Date:	Add/Change/Term Retiree:	Date:	Scan Retiree Forms:	Date:
Health Insurance Subsidy		FRS Online/OR		FRS: HIS and Confirmation to member file	
FRS Insurance Payroll Deduction Auth.		Self-Pay		FRS: Ins. Payroll Auth and Confirmation to member file	
		Business +		HR: Completed File	
				Move: Entire Benefit File-Active Employees to Benefits Files Retiree	