**Retiree Benefits Enrollment Form (Monthly)**
**2025 Plan Year**

| **Employee #:** | **Effective Date:** AUGUST 1, 2025 |
|---|---|

**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:** ☐M ☐F | **Date of Birth:** |
|---|---|---|---|---|---|
| | | | | | |

| **Street Address:** | **Apt #:** | **City:** | **State:** | **ZIP Code:** |
|---|---|---|---|---|
| | | | | |

| **Home Phone:** ( ) | **Cell Phone:** ( ) | **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed | **FRS Plan:** ☐ Investment ☐ Pension ☐ Self-Pay/Pension |
|---|---|---|---|
| | | | |

**Basic Life Insurance:**

| **Name of Beneficiary:** | **Relationship:** | **%:** | **Life Amount:** | **Premium:** |
|---|---|---|---|---|
| | | | | |

| **Name of Contingent** | **Relationship:** | **%:** |
|---|---|---|
| | | |

**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*** ☐ | | | ***Plan 2 (3769) BUY UP*** ☐ | | | ***Blue Options Grp Medicare*** ☐ |
|---|---|---|---|---|---|---|---|
| | *Category 1* | *Category 2* | *Category 3* | *Category 1* | *Category 2* | *Category 3* | |
| Single ☐ | $547.40 | $617.40 | $547.40 | $648.26 | $668.31 | $648.26 | $385.78 |
| Family ☐ | $1033.56<br>$1313.76<br>$933.18 | $1405.81 | $1033.56<br>$1313.76<br>$1405.81<br>$1003.18 | $1281.62<br>$1534.64<br>$1034.04 | $1582.10 | $1281.62<br>$1534.64<br>$1582.10<br>$1054.09 | $771.56 |

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

| **Dental** | ***Dental Plan 1*** ☐ | | | ***Dental Plan 2*** ☐ | | |
|---|---|---|---|---|---|---|
| | *Category 1* | *Category 2* | *Category 3* | *Category 1* | *Category 2* | *Category 3* |
| Single ☐ | $11.91 | $25.64 | $25.64 | $14.88 | $39.00 | $39.00 |
| Family ☐ | $22.64 | $49.42 | $49.42 | $36.59 | $65.58 | $65.58 |

| **Vision** | *Election* ☐ | *Category 1* | *Category 2* | *Category 3* |
|---|---|---|---|---|
| | Single ☐ | $7.10 | $8.87 | $8.87 |
| | Family ☐ | $14.21 | $22.77 | $22.77 |

| Administration Use Only: | |
|---|---|
| Code 315: | Code 316: |

***(Continued on Back Page)***

| **Dependent Information:** | | | | | **Election (E, C, T)**<br>E = Enroll<br>C = Continue<br>T = Term | | |
|---|---|---|---|---|---|---|---|
| *Name (Last, First, MI)* | *Relation* | *Social Security #* | *Gender* | *DOB* | *Med* | *Den* | *Vis* |
| | Sp | | | | | | |
| | Ch | | | | | | |
| | Ch | | | | | | |

**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 2024 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 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 with 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, placement for adoption, etc.
2. Qualifying events must be reported to the Human Resources Benefits Department within 30 days of the date of the event. Any changes submitted after this time period will not be approved.

**Preferred Method of Communication:**

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

X_____ Date:_____

Signature or legal representative signature

| 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 | |