CLASSIFIED SELF PAID RETIREES
Open Enrollment
Medical Plan Election Form
November 1, 2017 - September 30, 2018 Plan Year

INSTRUCTIONS:

PLEASE NOTE: Form MUST be returned to KCCD District Benefits Office, Human Resources (benefitsDOHR@kccd.edu) on or before September 25, 2017. These changes will be effective November 1, 2017.

Review the medical plan options below, select your medical plan option, then sign and date the form. Scan and email the signed form to benefitsDOHR@kccd.edu.

RETIREE AND DEPENDENTS UNDER AGE 65

(At least one person enrolled is under age 65. Enrollees over age 65 must have Medicare Parts A & B but will remain on the under 65 group enrollment)

SISC Pool Plans Effective November 1, 2017	Anthem PPO 100-A $20, Rx 5-20	Anthem PPO 90-G $20, Rx 7-25	Anthem PPO 80-G $30, Rx 7-25	Kaiser HMO* Trad HMO $10, Rx 10
Monthly Composite Rate (12)	$1,512.00	$1,302.00	$1,210.00	$1,201
Medical Election - Initial Elected Plan				
Classified Early Retiree Group Number	40816M	40816N	40816P	225543-3035

RETIREE AGE 65+ with MEDICARE PARTS A & B

(The rates below are applicable if all persons enrolled have Medicare Parts A & B)

SISC Pool Plans Circle which tiered rate below applies to your plan.	Anthem PPO 100-A $20, Rx 5-20	Anthem PPO 90-G $20, Rx 7-25	Anthem PPO 80-G $30, Rx 7-25	Kaiser HMO* Trad HMO $10, Rx 10
Single Rate	$653	$608	$608	$205
Two-Party Rate	$1,306	$1,216	$1,216	$410
Family Rate	$1,625	$1,514	$1,514	$866
Medical Election - Initial Elected Plan				
Classified RETIREE 65+ Group Number	40816R	40816S	40816T	225543-0311

*Enrollees under age 65 must complete a Kaiser Enrollment Form. For retirees or dependents over age 65 with Medicare must live in Kaiser Senior Advantage Service Area and complete a Kaiser Enrollment Form and a Kaiser Plan Election Form to assign Medicare to Kaiser

Retirees 65+ with Medicare Parts A & B interested in a Medicare Supplemental Plan - Companion Care, please contact HR for details.

Note: Premium payment for enrollment in coverages above is due by the 1st of the month of coverage beginning.

PRINT FULL LEGAL NAME _____ SIGNATURE _____ DATE _____

ADDRESS _____ PHONE _____

RETIREE SOCIAL SECURITY # _____ EMAIL _____

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