Retiree Health Enrollment

Selection and Deduction Agreement for Dental/Vision/Life/Dependent Coverage

Name (PRINT): _____ Date of Birth: _____
(Last) (First)

S S #: ___ ___ ___ -- ___ ___ -- ___ ___ ____ ____ Phone: _____ Email: _____

Address: _____
(Street) (City and State) (Zip)

I want to change my current benefits as indicated below. Please enroll in one of the following retirement benefits. Refer to current rate sheet for premiums.

Pension Plan	STRS	PERS	
Medical Waiver	Waiver form and proof of other group coverage attached.		OPT OUT
Certificated	Health Net	Health Net	Seniortate7341 0 TdDEMC 1 Tc 0 Tw 94 0 0 <004