City of Newport Beach Retiree Election Form

THIS FORM MUST BE RETURNED BY OCTOBER 16, 2020

PERSONAL INFORMATION

Name (First, MI, Last)	Birth Date	Social Security Number
Home Address	**Email Address**	**Phone**
Gender: Male ☐ Female ☐	**Marital Status:** Single ☐	Married ☐

Please confirm your enrollment status for the 2021 plan year below:

MEDICAL ELECTION

☐ I am **continuing** my CalPERS health plan enrollment for the 2021 plan year. Mark this box if you are continuing in your current health plan and have no changes or if you are changing from one health plan to another within the CalPERS options. Please process your change of health plan directly with CalPERS by calling 888-225-7377.

☐ I am **re-enrolling** into a CalPERS health plan effective January 1, 2021. Mark this box if you are currently opted out of CalPERS medical plans and enrolling in for 2021. Please process your enrollment directly with CalPERS by calling 888-225-7377.

☐ I am **declining** health coverage through CalPERS effective January 1, 2021. Mark this box if you have confirmed cancellation of coverage directly with CalPERS by contacting them at 888-225-7377.

If you are making any changes or enrolling in a CalPERS plan, **YOU MUST** contact CalPERS at 888-225-7377 by Friday, October 16, 2020.

DENTAL ELECTION *(MUST BE CURRENTLY ENROLLED)*

	Monthly Premium		
	RETIREE ONLY	**RETIREE + ONE**	**RETIREE + 2 OR MORE**
MetLife Dental DHMO *(California Residents only)*	☐ $14.03	☐ $26.65	☐ $37.17
MetLife Dental PPO, High (*$3,000 annual maximum, available to Retirees in & out of California*)	☐ $54.57	☐ $111.04	☐ $152.69
MetLife Dental PPO, Low (*$1,000 annual maximum, available to Retirees outside of California only*)	☐ $37.12	☐ $72.33	☐ $122.41

☐ **Cancel Existing Dental Coverage**

VISION ELECTION (*MUST BE CURRENTLY ENROLLED)*

	Monthly Premium		
	RETIREE ONLY	**RETIREE + ONE**	**RETIREE + TWO OR MORE**
MetLife Vision	☐ $8.76	☐ $16.79	☐ $23.99

☐ Cancel Existing Vision Coverage

DEPENDENT INFORMATION

Enter all information for each dependent and check the appropriate boxes to indicate the coverage(s). If you need more space, please use a separate sheet of paper. Do not check both Add and Delete box within one line, use additional sheet of paper if necessary. **PLEASE PRINT CLEARLY**

Dependent Information		**Relationship**	**SSN#**	**Date of Birth**	Coverages Elected Check all that apply.	
					Dental	**Vision**
1 ☐ Add ☐ Del.	Name	Spouse:☐ M ☐ F				
2 ☐ Add ☐ Del.	Name	Child:☐ M ☐ F				
3 ☐ Add ☐ Del.	Name	Child:☐ M ☐ F				

RETIREE AUTHORIZATION

I verify that all the information I supplied and/or corrected on this enrollment form is true and complete to the best of my knowledge. I understand that by signing this form, I am making a binding election for my benefits for the period January 1, 2021 through December 31, 2021. I further understand that I may not change my benefit elections unless the changes are a result of and consistent with a qualified status change (e.g., marriage, divorce, birth or adoption, death of a dependent, change in my spouse's employment status that affects my spouse's benefits eligibility under another employer's plan, etc.). I understand that if I experience a qualified status change, I must notify Human Resources within 60 days of the status change.

Please return completed forms to City of Newport Beach, Human Resources by October 16, 2020 via mail, fax or email.

- **Mail: P.O. Box 1768, Newport Beach, CA 92658-8915**
- **Fax: 949-644-3305**
- **Email: HRBenefit@newportbeachca.gov**

_____ _____

Retiree Signature **Date**