



City of Newport Beach Retiree Election Form

THIS FORM MUST BE SUBMITTED to BCC BY OCTOBER 15, 2021

PERSONAL INFORMATION

Name (First, MI, Last)	Birth Date	Social Security Number
Home Address	Email Address	Phone
Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>	Marital Status: Single <input type="checkbox"/> Married <input type="checkbox"/>	

Please check the appropriate box below to confirm your enrollment status for the 2022 plan year.

MEDICAL ELECTION

- I am **continuing** my CalPERS health plan enrollment for the 2022 plan year. Mark this box if you are continuing in your current health plan or if you are changing from one health plan to another with CalPERS. If you plan on making a health plan change, please process your change directly with CalPERS by calling 888-225-7377 by October 15, 2021.
- The 2022 CalPERS health plan contribution is \$149 which is paid directly to CalPERS on your behalf and applied towards the cost of your medical insurance premium. Hybrid Retiree Health Savings (RHS) plan participants receive the remaining balance of the monthly City contribution into their RHS account.*
- I am **declining** health coverage through CalPERS effective January 1, 2022. Mark this box if you currently decline PERS health coverage, or if you will be canceling coverage for 2022. To confirm your cancellation of coverage, contact CalPERS directly by calling 888-225-7377.

If you are making any changes to or enrolling in a CalPERS medical plan, **YOU MUST** log into your myCalPERS account at www.mycalpers.ca.gov or contact CalPERS at 888-225-7377 by Friday, October 15, 2021.

DENTAL ELECTION (MUST BE CURRENTLY ENROLLED)

Monthly Premium

	RETIREE ONLY	RETIREE + ONE	RETIREE + 2 OR MORE
MetLife Dental DHMO <i>(California Residents only)</i>	<input type="checkbox"/> \$14.03	<input type="checkbox"/> \$26.65	<input type="checkbox"/> \$37.17
MetLife Dental PPO, High <i>(\$3,000 annual maximum, available to Retirees in & out of California)</i>	<input type="checkbox"/> \$54.57	<input type="checkbox"/> \$111.04	<input type="checkbox"/> \$152.69
MetLife Dental PPO, Low <i>(\$1,000 annual maximum, available to Retirees outside of California only)</i>	<input type="checkbox"/> \$37.12	<input type="checkbox"/> \$72.33	<input type="checkbox"/> \$122.41

- Cancel my dental coverage for 2022.

**Cancellation of coverage by the Retiree precludes re-enrollment in the future.*

VISION ELECTION (MUST BE CURRENTLY ENROLLED)**Monthly Premium**

	RETIREE ONLY	RETIREE + ONE	RETIREE + TWO OR MORE
MetLife Vision	<input type="checkbox"/> \$8.76	<input type="checkbox"/> \$16.79	<input type="checkbox"/> \$23.99

Cancel my vision coverage for 2022.

**Cancellation of coverage by the Retiree precludes re-enrollment in the future.*

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 sheets of paper if necessary. **PLEASE PRINT CLEARLY**

	Dependent Information	Relationship	SSN#	Date of Birth	Coverages Elected	
					Dental	Vision
1 <input type="checkbox"/> Add <input type="checkbox"/> Del.	Name	Spouse: <input type="checkbox"/> M <input type="checkbox"/> F				
2 <input type="checkbox"/> Add <input type="checkbox"/> Del.	Name	Child: <input type="checkbox"/> M <input type="checkbox"/> F				
3 <input type="checkbox"/> Add <input type="checkbox"/> Del.	Name	Child: <input type="checkbox"/> M <input type="checkbox"/> 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, 2022 through December 31, 2022. 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 submit completed and signed forms to Benefit Coordinators Corporation (BCC), by October 15, 2021 via mail, fax or email.

- **Mail:** Benefit Coordinators Corporation (BCC)
Two Robinson Plaza, Suite 200, Pittsburgh PA, 15205
- **Fax:** (412) 276-6650 / Phone: (800) 685-6100
- **Email:** customersupport@benxcel.com

Retiree Signature _____

Date _____