City of Newport Beach Retiree Election Form

THIS FORM MUST BE SUBMITTED to BCC BY OCTOBER 13, 2023

PERSONAL INFORMATION

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

Please check the appropriate box below to confirm your enrollment status for the 2024 plan year.

MEDICAL ELECTION

☐ I am **continuing** my CalPERS health plan enrollment for the 2024 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 13, 2023.

- *The 2024 CalPERS health plan contribution is $157 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, 2024. Mark this box if you currently decline PERS health coverage, or if you will be canceling coverage for 2024. 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 13, 2023.**

DENTAL ELECTION (*MUST BE CURRENTLY ENROLLED*)

	Monthly Premium		
	RETIREE ONLY	**RETIREE + ONE**	**RETIREE + 2 OR MORE**
Delta Dental DHMO *(California Residents only)*	☐ $16.11	☐ $30.59	☐ $42.67
Delta Dental PPO, High (*$3,000 annual maximum, available to Retirees in & out of California)*	☐ $55.25	☐ $112.42	☐ $154.58
Delta Dental PPO, Low (*$1,000 annual maximum, available to Retirees outside of California only)*	☐ $35.79	☐ $69.74	☐ $118.03

Cancel my dental coverage for 2024 ☐

Cancellation of coverage by the Retiree precludes re-enrollment.

VISION ELECTION (*MUST BE CURRENTLY ENROLLED)*

	Monthly Premium		
	RETIREE ONLY	**RETIREE + ONE**	**RETIREE + TWO OR MORE**
VSP Vision	☐ $8.926	☐ $17.83	☐ $28.71
Cancel my vision coverage for 2024	☐		

Cancellation of coverage by the Retiree precludes re-enrollment.

DEPENDENT INFORMATION

Enter all information for each dependent you wish to enroll 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 the 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 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, 2024, through December 31, 2024. 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 BCC within 60 days of the status change.

Please submit completed and signed forms to Benefit Coordinators Corporation (BCC), by October 13, 2023, 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** _____