Retiree Insurance Benefits Request Form

Name of Retiree: ______________________ Identification #: ______________
Address: ____
City: ______________ State: _____ Zip: _______ Home Phone: (____)__________
Social Security #: _______________ Spouse's Social Security #: _______________
Date of Retirement: _______________ Last Month of Coverage Paid by Employer: ________
Medical Insurance: ❑ Single ❑ Two Party ❑ Family **Dependent Coverage:** ❑ Yes ❑ No
Amount of Life Insurance Coverage: $____________
Monthly Health Premiums: $__________ Last Month of Coverage Paid by Employer: ________
School District Number and Address: ______________________________
Signature of School District Official: ______________________ Date: ________

Please Check Appropriate Coverage:

	Name	Date of Birth	Under 65 Without Medicare	Over/Under 65 With Medicare	
				Option 1	Option 2
Insured					
Spouse					
Children					

Total Monthly Insurance Premiums to be Paid by PERS: $ ______________

Please pay my insurance premiums in the total amount shown above until my sick leave entitlement is exhausted. After my sick leave entitlement has been exhausted, I request the Public Employee Retirement System to continue my health care coverage by withholding the required premiums from my retirement allowance until otherwise notified in writing.

Retiree's Signature: ______________________________ Date: ______________

This form is to be completed and signed by the school district official and the retiree. A copy must be sent to Regence BlueShield of Idaho and PERS prior to the tenth of the month before retirement.

6/2002

501371