FRESNO UNIFIED SCHOOL DISTRICT

2309 Tulare Street Fresno, CA 93721 (559) 457-3520 Fax No. (559) 457-3760

Open Enrollment Form
For **Benefited** Retirees
Changes Effective April 1, 2012

RETIREE INFORMATION

LAST NAME	FIRST NAME	EMPLOYEE ID OR SSN NUMBER	☐ SINGLE ☐ MARRIED ☐ DOMESTIC PARTNERSHIP
MAILING ADDRESS			
CITY STATE ZIP CODE	BIRTHDATE	TELEPHONE NO.	☐ MALE ☐ FEMALE

OTHER HEALTH INSURANCE INFORMATION

Is your spouse employed? ☐ YES ☐ NO IF YES, WHERE _____

Are you or any family members covered by another group plan? ☐ NO ☐ YES _____
GROUP NAME

FRESNO UNIFIED SCHOOL DISTRICT MEDICAL PLANS

Option A ☐	**PPO Providers**	**Non PPO**
Covered Services	80% of UCR*	60% of UCR*
Calendar Year Deductible	$250 Individual $500 Family	$750 Individual $1,500 Family
Annual Out-Of Pocket Maximum	$5,000 Individual $10,000 Family	$10,000 Individual $20,000 Family
Office Co Pay	$15	$0

***Usual, Customary and Reasonable**

PREMIUMS	**65 & Under**	**65-74**	**75+**
Retiree Only	**$160.00***	**$10.00**	**N/C**
Retiree & Child	**$175.00***	**$20.00**	**N/C**
Retiree & Spouse or Domestic Partner	**$220.00***	**$20.00**	**N/C**
Retiree & Family	**$230.00***	**$40.00 Max**	**N/C**

*Additional Monthly Assessment Fee of $10.00 applies to 65 & Under

☐ ADD Coverage ☐ DROP Coverage

☐ Retiree Only
☐ Retiree/Spouse Coverage
☐ Retiree/Family Coverage
☐ Dependent or Spouse

☐ Delete Retiree Coverage
☐ Delete Dependent Coverage
☐ Delete Family Coverage

Option B ☐	**PPO Providers**	**Non PPO**
Covered Services	70% of UCR*	50% of UCR*
Calendar Year Deductible	$1,000 Individual $2,000 Family	$3,000 Individual $6,000 Family
Annual Out-Of Pocket Maximum	$6,000 Individual $12,000 Family	$12,000 Individual $24,000 Family
Office Co Pay	$25	$0

***Usual, Customary and Reasonable**

PREMIUMS	**65 & Under**	**65-74**	**75+**
Retiree Only	**$60.00***	**$10.00**	**N/C**
Retiree & Child	**$70.00***	**$20.00**	**N/C**
Retiree & Spouse or Domestic Partner	**$90.00***	**$20.00**	**N/C**
Retiree & Family	**$100.00***	**$40. Max**	**N/C**

*Additional Monthly Assessment Fee of $10.00 applies to 65 & Under

☐ ADD Coverage ☐ DROP Coverage

☐ Retiree Only
☐ Retiree/Spouse Coverage
☐ Retiree/Family Coverage
☐ Dependent or Spouse

☐ Delete Retiree Coverage
☐ Delete Dependent Coverage
☐ Delete Family Coverage

Continue on reverse side

COMPLETE NEXT SECTION IF YOU ARE ADDING OR DROPPING DEPENDENTS

FAMILY INFORMATION – If you are adding a dependent or spouse, you must provide a copy of the Birth, Marriage or Domestic Partner Certificate.

FIRST NAME	LAST NAME	GENDER	AGE	BIRTHDATE	SOCIAL SECURITY
☐ DOMESTIC PARTNER ☐ SPOUSE		F / M			
☐ SON ☐ DAUGHTER		F / M			
☐ DOMESTIC PARTNER ☐ SPOUSE		F / M			
☐ SON ☐ DAUGHTER		F / M			
☐ SON ☐ DAUGHTER		F / M			
☐ SON ☐ DAUGHTER		F / M			
☐ SON ☐ DAUGHTER		F / M			
☐ DOMESTIC PARTNER ☐ SPOUSE		F / M			
☐ SON ☐ DAUGHTER		F / M			

- The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides for continued group health care coverage for employees and family members at their own expense. Contact the Benefits Office for continuation of coverage due to a qualifying event.

- Please notify the Benefits Office of any change in Health Coverage within 31 days of event.

RETIREE SIGNATURE_____ **Date** _____

Verified by:	Effective Date: