



Office of Human Resources & Employee Relations
 AVC HEALTH PLAN ELECTION FORM

CHECK APPLICABLE BOX: RETIRED TRUSTEES, RETIRED ADMINISTRATORS AND RETIRED CMS UNDER 65

OPEN ENROLLMENT DEADLINE FRIDAY, SEPTEMBER 4th, 2018

PLEASE SELECT YOUR PLAN CHOICE FROM THE LIST BELOW FOR THE 10/2018-9/2019 SCHOOL YEAR:

EMPLOYEE NAME: _____ SSN: _____

Print Clearly

NOTE: If changing plans from PPO to Kaiser or Kaiser to PPO, you MUST complete SISC III/Kaiser enrollment forms and provide required documents (See #2 below). If just changing from a PPO to PPO or Kaiser to Kaiser plan ONLY complete this form (AVC Health Plan Election Form).

Remaining on plan selected below (ONLY need to complete and submit this form) no additional paperwork required.

Changing plan to plan selected below and attached required enrollment form SISC III PPO or Kaiser HMO (see # 2 below)

Self-Insured Schools of California (SISC III) Plan Choices Retiree District Cap \$14,000.00 Additional benefits offered beyond the medical plans include, Delta Dental #7079 2390, Medical Eye Services #31231-002 and Term Life Group #G000AMP6 Class Code A001/A005	<input checked="" type="checkbox"/>	Retiree Only	<input checked="" type="checkbox"/>	Retiree + 1 12-month deduction**	<input checked="" type="checkbox"/>	Retiree + Family 12-month deduction**
OPO21002 , Blue Shield PPO 100% - A, \$20 co-pay, Rx 7-25, \$0 Deductible		\$0		\$540.33		\$527.23
OPO41002 , Blue Shield PPO 100% -C, \$20 co-pay, Rx 9-35,\$200 Ind./\$400 Family Deductible		\$0		\$472.33		\$458.23
OPO11002 , Blue Shield PPO 90% - C, \$30 co-pay, Rx 9-35, \$200 Ind./\$500 Family Deductible		\$0		\$384.33		\$370.23
OPO31002 , Blue Shield PPO 80% - G, \$30 co-pay, Rx 9-355, \$500 Ind. /\$1000 Family Ded.		\$0		\$221.33		\$207.23
225543-0945 , Kaiser HMO, \$10 co-pay, Rx \$10, \$0 Deductible		\$0		\$90.33		\$136.23
225543-3017 , Kaiser HMO, \$30 co-pay, Rx \$10-\$30, \$0 Deductible		\$0		\$48.33		\$92.23

PLEASE CHECK CORRESPONDING BOX: I wish to continue medical, dental and vision coverage as a Retiree under age 65 I do not wish to continue medical, dental and vision coverage as a Retiree under age 65

IMPORTANT: Please provide your contact information to Human Resources.

Address: _____ City: _____ State: _____ Zip: _____

Date of birth: _____ Home phone: _____ Cell phone: _____ E-mail: _____

BENEFIT PAYMENTS: I understand that the monthly Retiree Cost applicable to the Plan I have selected will be due the 1st day of the month. If payments are not made on time insurance coverage will be terminated. **Please make checks payable to Antelope Valley College and submit payment to the Human Resources Office Attention Vicky Remp**

Employee Signature (required): _____ Date: _____

- NOTES:**
- (1) Kaiser, as an HMO, does not coordinate benefits with indemnity (Blue Cross or Blue Shield) policies. Spouses not primarily covered on an HMO are limited to the use of their own plans. Dependents of parents having both an indemnity plan and an HMO are provided primary coverage based on the parent whose birthdate falls earliest in the calendar year, as is the case with both parents having indemnity plans.
 - (2) A new Enrollment form must be completed for any changes of plan, addition or removal of dependents, etc. If applicable, employee must provide required document (adding spouse: 2017 tax return, dependents birth certificate, if removing spouse outside of open enrollment need divorce decree). All changes apply to dental, vision and life coverage.