



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.