



ENROLLMENT FORM FOR 2026 RETIREE BENEFITS



PERSONAL INFORMATION:

<u>Name (Last, First, MI)</u>		<u>Social Security Number</u>		<u>Date of Birth</u>		<u>Sex</u> M <input type="checkbox"/> F <input type="checkbox"/>	
<u>Address (Street, No.)</u>		<u>City</u>		<u>State</u>		<u>Zip</u>	
				<u>Phone #</u>		<u>Employee #</u>	
<u>Email Address</u>				<u>Retirement Date</u>			
				<u>Coverage Effective Date</u>			

COVERAGE ELECTIONS (monthly rates)

	Decline	Retiree Only	Retiree + Spouse	Retiree + Child(ren)	Retiree + Family
Choice Plus		\$399.00	\$798.00	\$718.00	\$1,196.00
EPO Choice		\$377.00	\$754.00	\$674.00	\$1,147.00
Dental		\$52.00	\$69.00	\$72.00	\$105.00
Vision		\$5.86	\$9.96	\$10.54	\$15.62

MONTHLY SURCHARGES (medical plans only) SELECT ONE:

___ 5 – 9 Years of Service: \$100.00 ___ 10 – 19 Years of Service: \$50.00 ___ 20 + Years of Service: \$0.00

Coverage Selection		Last Name (if different from employee name)	First Name	MI.	Sex M F	Date of Birth	Social Security Number
<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	Spouse				<input type="checkbox"/> <input type="checkbox"/>		
<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	Child				<input type="checkbox"/> <input type="checkbox"/>		
<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	Child				<input type="checkbox"/> <input type="checkbox"/>		
<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	Child				<input type="checkbox"/> <input type="checkbox"/>		

ACKNOWLEDGEMENT AND SIGNATURE:

My signature below acknowledges that I understand that eligibility in the City of Round Rock Retiree Benefits Coverage will terminate upon my and/or my dependent's eligibility for health coverage with another employer, and/or my and/or my dependent's eligibility for Medicare. I also understand it is my responsibility to inform the City of Round Rock in the event I become eligible for health coverage with another employer. Failure to do so will cause my retiree benefits with the City of Round Rock to terminate.



Signature

Date