2027 RETIREE BENEFITS

Name (First, Last, MI):	Phone Number:	EE Number:

Email Address:	Retirement Date:	Coverage Effective:

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	$72.00	$69.00	$105.00
Vision LOW		$5.86	$9.96	$10.54	$15.62
Vision HIGH		$11.40	$19.40	$20.54	$30.46
Ambulance		$9.50	$20.50	$20.50	$20.50

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	First Name	MI.	Sex M F	Date of Birth	Social Security Number
☐ Medical ☐ Dental ☐ Vision ☐ Ambulance	Spouse				☐ ☐		
☐ Medical ☐ Dental ☐ Vision ☐ Ambulance	Child				☐ ☐		
☐ Medical ☐ Dental ☐ Vision ☐ Ambulance	Child				☐ ☐		
☐ Medical ☐ Dental ☐ Vision ☐ Ambulance	Child				☐ ☐		

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.

X _____ **Signature**

_____ **Date**