RETIREE

SUBMIT FORM TO: Benefits Department

56 South Lincoln Street • Stockton, CA 95203
Office: (209) 933-7026
Fax: (209) 933-7011
Email: benefits@stocktonusd.net

Date: _____

DELTA DENTAL PPO GROUP

❒ 6540-0020 RETIRED ❒ 6540-0008 SPPA RETIRED

EyeMed VISION GROUPS

❒ HMO (Hardware Only) - 1036708 ❒ PPO (Exam & Hardware) - 1039288

TYPE OF ACTION *(Check Boxes That Apply)*

Effective Date: _____

❒ Retiree New Enroll
❒ Open Enrollment
❒ Adding Dependent(s)
❒ Drop Coverage - Retiree
❒ Drop Coverage – Dependent(s)
❒ Change of Coverage

RETIREE INFORMATION

Gender: ❒ Male ❒ Female Marital Status: ❒ Single ❒ Married, Date of Marriage *(Required)*: _____

Name: _____ Date of Birth: _____/_____/____

Social Security#: _____ Date of Hire: _____/_____/_____ Retired Date: _____/_____/____

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

Telephone Number: _____ E-mail (optional): _____

ONLY LIST DEPENDENT(S) TO BE COVERED UNDER PLAN(S):

DEPENDENT *(Check One)* ❒ **Spouse** ❒ **Registered Domestic Partner**

NAME	DATE OF BIRTH	SOCIAL SECURITY #	GENDER	
			F	M

CHILDREN *(List All Eligible Dependent Children)*

NAME	DATE OF BIRTH	SOCIAL SECURITY #	DISABLED DEP		GENDER	
			Y	N	F	M
			Y	N	F	M
			Y	N	F	M
			Y	N	F	M

_____ _____
Retiree Signature *(Form must be signed to be processed)* **Date**

_____ _____
Benefits Staff Signature **Date**