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

OptumHealth Chiropractic Benefit Enrollment Form

Date: ________________

RETIREE INFORMATION

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

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

Social Security#: _________________________ Date of Retirement: _____/_____/_____

Address: ____________________________________ City: ___________________ State: _____ Zip:_________

Telephone Number: ___________________________ E-mail (optional): ________________________________

TYPE OF ACTION *(Check Boxes That Apply)*

Effective Date: ________________

❐ Retiree New Enroll ❐ Drop Coverage - Retiree
❐ Adding Dependent(s) ❐ Drop Coverage – Dependent(s)

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

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**