City of Lake Worth Beach

Retiree Enrollment / Change Form

Fiscal Year: _____

Last Name	First	MI	SS# (last 4 only)	Date of Birth

Date of Retirement	Effective Date

Elect coverage(s): Circle appropriate monthly rate for selected coverage(s) and enter total on line below.

Benefit Type	Retiree Only	Emp+Spouse	Emp+Child/ren	Family
Cigna Medical PPO	$ 769.77	$ 1,590.45	$ 1,444.73	$ 2,403.47
Cigna Dental PPO	$ 29.96	$ 55.30	$ 75.25	$ 115.27
Cigna Dental HMO	$ 18.38	$ 33.77	$ 41.40	$ 60.81
Eyemed Vision	$ 5.70	$ 11.42	$ 9.67	$ 15.96

Total Premium: $ _____

These premiums will be deducted from your pension check on a monthly basis.

Waive / Drop Coverage(s): Check the benefit coverage(s) that you are waiving / dropping below.

_____ Medical _____Dental _____Vision _____Voluntary Life (All)

Authorization: I have received benefit plan information for the plan year indicated above. I understand that I am selecting benefits now for the entire plan year. I understand that I may cancel my benefits at any time during the year ONLY with a Qualifying Event. If I cancel at any time, I waive my right to participate or enroll in that benefit art any time in the future. I understand that if I did not apply for coverage at this time, no coverage will be available to me a any time in the future.

Signature: _____ Date: _____

Printed Name: _____