

Employee ID# _____

2027 Open Enrollment is October 5, 2026 - October 30, 2026!

CalPERS ☐ or SCERS ☐

Contact Information (Retiree/Surviving Beneficiary) – REQUIRED

☐ Check here if this is a new address

First and Last Name: _____

Address: _____

Home Phone: _____

Cell Phone: _____

Email: _____

Return a signed copy of this document or complete the online enrollment form, even if you are not making any changes to your benefits. Effective date of coverage is January 1, 2027.

☐ I am **NOT** making changes to my current benefits. Complete remainder of this page, sign, and return. Do not fill out the back of this form.

☐ I am making changes to my current benefits. Complete BOTH sides of this form. Only fill out the sections that you are changing on the back of this form.

Emergency Contact – REQUIRED

☐ Check here if this is new/updated emergency contact information

Name	Phone	Relationship
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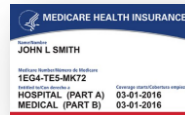
Dependent Information – REQUIRED if plan lists dependents above or if adding new dependents

1. Full Name	Relationship ☐ Spouse ☐ Child	Medical ☐ Add ☐ Remove
SSN	DOB	Dental ☐ Add ☐ Remove
	Disabled ☐ Yes ☐ No	Vision ☐ Add ☐ Remove
2. Full Name	Relationship ☐ Spouse ☐ Child	Medical ☐ Add ☐ Remove
SSN	DOB	Dental ☐ Add ☐ Remove
	Disabled ☐ Yes ☐ No	Vision ☐ Add ☐ Remove
3. Full Name	Relationship ☐ Spouse ☐ Child	Medical ☐ Add ☐ Remove
SSN	DOB	Dental ☐ Add ☐ Remove
	Disabled ☐ Yes ☐ No	Vision ☐ Add ☐ Remove

Retiree Signature _____ **Date** _____

Signature required for City to process form.

ONLY COMPLETE THIS PAGE IF YOU SELECTED "I am making changes to the benefits listed above" ON FRONT OF FORM

1. MEDICAL			
Changes:	Non-Medicare Plans:	Medicare Plans:	Coverage Level:
☐ Remove Coverage ☐ Enroll/Edit Coverage ☐ Enroll in Cash In-Lieu (See Cash In-Lieu box below)	☐ Kaiser Permanente ☐ Western Health Advantage ☐ Sutter Health Plus <u>Co-Pay Options:</u> ☐ \$25 ☐ \$40	☐ Kaiser Senior Advantage \$20 ☐ UnitedHealthcare \$15 Note: If selecting a Medicare plan please attach a copy of your Medicare card (and spouse's if applicable). 	☐ Retiree only ☐ Retiree & 1 Dependent* ☐ Retiree & 2+ Dependents*

2. DENTAL			3. VISION		
Changes:	Dental Plans:	Coverage Level:	Changes:	Vision Plans:	Coverage Level:
☐ Remove Coverage ☐ Enroll/Edit Coverage	☐ Delta Care DMO ☐ Delta Dental PPO	☐ Retiree only ☐ Retiree & 1 Dependent* ☐ Retiree & 2+ Dependents*	☐ Remove Coverage ☐ Enroll/Edit Coverage	☐ VSP Basic ☐ VSP Enhanced	☐ Retiree only ☐ Retiree & 1 Dependent* ☐ Retiree & 2+ Dependents*

Changes Summary

***If you have selected coverage level of Retiree & 1 Dependent or Retiree & 2+ Dependents, please make sure dependent information is listed on page 1.**

<u>Cash In-Lieu</u> If you receive a retiree health contribution from the City, you may request a monthly reimbursement from the City of Sacramento for individual medical premiums. If you select dental and/or vision coverage with the City of Sacramento, the monthly premium(s) will be subtracted prior to calculating your cash in-lieu reimbursement amount. If electing cash in-lieu for 2027, additional information and forms <u>will be mailed</u> to you in mid-November.	<u>Important Reminders</u> Proof documentation for dependent eligibility is due by November 13, 2026. If you need to complete a carrier enrollment form, the form will be mailed to you after we have reviewed your OE form. Carrier enrollment forms must be completed and mailed back to Benefit Services as soon as possible, but no later than December 1, 2026.	<u>Return This Completed Form by October 30, 2026</u> Mail: City of Sacramento - Benefit Services 915 I Street, Plaza Level Sacramento, CA 95814 Questions? Call 916-808-5665 Email retireeOE@cityofsacramento.org Visit us online at https://www.cityofsacramento.gov/HR/employee-retiree-benefits
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