Washoe County School District
Retiree Enrollment

Effective Date of Retirement: _____

Location Site (Required): _____

Last Name	First Name	MI	SSN		Employee # E000
Physical Address	City	State	Zip Code	Date of Birth	Phone
Mailing Address	City	State	Zip Code	Email Address	

1. Status: Certified____ ESP____ Administrator ____ Confidential_____ **2. Hire Date**: _____

3. Effective Date of PERS: _____ **4. Current Plan** PPO ____ QHDHP ____

5. Dependent Information if covered:

Relationship	Last Name	First	MI	Birthday	Sex M/F	Reside w/ EE Y/N	Dependent Social Security #	Email Address	Elig Docs
Spouse									
Child									
Child									

$_____ Retiree Health Premium

____ Eligible for subsidy

____ Medicare Enrolled

$_____ Spouse Health Premium

____ Medicare Enrolled

$_____ 1 Child Health Premium

$_____ 2 Children Health Premium

$_____ Family Health Premium

$_____ Vision Premium (Retiree & Eligible Dependents)

$_____ Basic Life Insurance**

☐$40,000 Limit (Cert/ESP) ☐$50,000 Limit (Admin/Confidential) ☐$200,000 Limit (Admin)

____ age 70 or over

$_____ Additional Life Insurance** (Premium based on age and limits)

Value of Supplemental Life Insurance _____

$_____ Retiree Gap Premium (PPO Only)

$_____ Dependent Gap Premium (PPO Only)

$_____ Retiree Non-Discount Premium

$_____ Spouse Non-Discount Premium

$_____ **Total Health Premium to be pulled from PERS Check**

*The subsidy is subject to negotiations and could change. The subsidy is for ESP Staff hired prior to July 1, 1999 with more than 15 years of service. There is no subsidy for Certified/Admin Staff.

**The total combined limit of Basic Life and Additional Life that may be combined is $200,000.

Employee Certification:

With my signature, I hereby declare, certify and state under penalty of perjury that the information I have provided here is true and correct, that any dependents listed above are eligible under my Employer's Dependent Benefit Criteria. Further, I understand that the information supplied, herein, may be used by my Employer in order to verify my dependent(s) for purpose of coverage, to make decisions about my coverage under my Employer's employee benefit plans and as otherwise necessary in connection with managing the organization's employee benefits plans. Finally, I understand that if required documents have not been provided by my Employer's deadline, my non-verified dependents' coverage will be terminated.

I authorize WCSD to deduct the premiums indicated above from my PERS retirement check. I understand these premiums are subject to periodic changes. Therefore, I authorize WCSD to deduct these premium changes from my PERS retirement check as required. If premium is not deducted from PERS check, Retiree must notify and pay WCSD Health Insurance Fund directly by the 25th of the month. Failure to report any errors in premium contributions to the Risk Management Office could result in loss of contributions. A maximum of two (2) months of contributions will be reimbursed for overpayment due to non-notification.

Employee Signature _____ Date Signed _____

DISTRICT USE ONLY:

Employer Signature _____