BENEFITS ADMINISTRATION | THE CLAREMONT COLLEGES SERVICES

2026 Retiree Benefits Enrollment Form

Effective Date: _____ College: _____

Name: _____ Date of Birth: _____

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

Email: _____ Phone: _____

MEDICAL PLAN ENROLLMENT (Non Medicare retirees only)	Retiree Only	Retiree + Spouse	Retiree + Child(ren)	Family
☐ Blue Shield Trio HMO	☐ $636.67	☐ $1,337.00	☐ $1,146.00	☐ $1,973.67
☐ Blue Shield Access + HMO	☐ $796.18	☐ $1,671.97	☐ $1,433.12	☐ $2,468.15
☐ Blue Shield HDHP	☐ $1,209.63	☐ $2,540.24	☐ $2,177.35	☐ $3,749.88
☐ Kaiser HMO	☐ $870.29	☐ $1,827.61	☐ $1,566.52	☐ $2,697.90
☐ I do not wish to continue my medical coverage				

Kaiser Permanente Senior Advantage (M = Medicare / NM = Non Medicare
Complete this section if you are eligible for Medicare and wish to enroll in KPSA. Choose a coverage level.

☐ Retiree Only	$173.40	☐ Retiree (NM) + Spouse (M)	$1,046.07
☐ Retiree (M) + Spouse (M)	$346.80	☐ Retiree (M) + Spouse (M) + Child (NM)	$1,132.20
☐ Retiree (M) + Spouse (NM)	$1,133.34	☐ Retiree (M) + Spouse (NM) + Child (NM)	$1,918.74
☐ I do not wish to continue my medical coverage		☐ Retire (NM) + Spouse (M) + Child (NM)	$1,831.47

DENTAL PLAN ENROLLMENT	Retiree Only	Retiree + 1	Retiree + Family
☐ Cigna DHMO	☐ $17.70	☐ $31.02	☐ $52.60
☐ Cigna PPO	☐ $62.01	☐ $121.84	☐ $240.49
☐ I do not wish to enroll in dental coverage			

VISION PLAN ENROLLMENT	Retiree Only	Retiree + 1	Retiree + Family
☐ Vision Service Plan (VSP) Core plan	☐ $ 1.85	☐ $ 2.96	☐ $ 4.81
☐ Vision Service Plan (VSP) Buy-Up	☐ $ 8.97	☐ $ 14.34	☐ $ 23.31
☐ I do not wish to enroll in vision coverage			

RETIREE AND DEPENDENT INFORMATION

Please complete the following information for any dependents covered under The Claremont Colleges medical, dental and vision plans. If you and/or your dependents(s) have elected a Blue Shield HMO or Cigna DHMO, please elect a medical/dental provider.

Name	DOB	Gender	Relationship	PCP# Doctor #	Dental Facility

Life Insurance	Complete this section to enroll in the Retiree Life Insurance Plan. The coverage amount is $5,000 and the monthly premium is based on your age.		
☐ Waive/Cancel Coverage	**Monthly Rate**	**Age**	**Monthly Rate**
☐ 55-59	$2.33	☐ 75-79	$18.49
☐ 60-64	$3.47	☐ 80-84	$26.65
☐ 65-69	$5.89	☐ 85-89	$41.09
☐ 70-74	$10.84	☐ 90-94	$63.59

LIFE INSURANCE BENEFICIARY - The person(s) you name as beneficiary below will replace any previous designations you've made. For each person named, indicate the percentage of benefit he or she is to receive from the plan. Each column should total 100%.

	Beneficiary Name	Relationship	Address (leave blank if same)	DOB	%
Primary Beneficiary					
					Must total 100%
Contingent Beneficiary					
					Must Total 100%

Kaiser Permanente Arbitration Agreement (please sign if you elected Kaiser)

I understand that, except for Small Claims Court cases and claims subject to a Medicare appeals procedure, and dispute between myself, my heirs or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, service or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up my right to a jury trial and accept the use of binding arbitration. I understand that the arbitration provision is contained in the Evidence of Coverage.

Kaiser Permanente Senior Advantage Premium Acknowledgement: I acknowledge that if I make a change in my Kaiser membership or Medicare enrollment information, I may be liable for additional premiums. I understand that in the event my Medicare assignment to Kaiser should change and additional premiums are billed, I will be responsible for the difference in premiums.

Signature _____ Date _____

Authorization and Signature (please sign)

AUTHORIZATION AND SIGNATURE: I understand that I must notify Benefits Administration promptly if I wish to change my elections. I agree to abide by the provisions of membership in the Plan(s) as stated in my group's contract and my Evidence of Coverage, including the clause compelling binding arbitration of unresolved disputes regarding services, including claims of medical malpractice. NON-PARTICIPATING PROVIDER: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider. I have read and understood the provisions set out on this form. All information on this form is correct and true. I understand that it is the basis on which coverage may be issued under the plan. Any misstatements or omissions may result in future claims being denied and/or my coverage being declined.

Signature _____ Date _____