

IMPORTANT!

REQUEST FOR ENROLLMENT FORMS

Enrollment forms are also available on the Brochures & Forms page of lacera.com under Retiree Healthcare.

TO BE COMPLETED BY RETIREE

MEMBER'S NAME _____

MEMBER'S EMPLOYEE NUMBER _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

DAYTIME TELEPHONE NUMBER (____) _____

LACERA – ADMINISTERED MEDICAL PLANS (check one of the following boxes)

INDEMNITY PLANS

For: Myself Dependents

- | | | |
|---|--------------------------|--------------------------|
| <input type="checkbox"/> ANTHEM BLUE CROSS I | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> ANTHEM BLUE CROSS II | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> ANTHEM BLUE CROSS PRUDENT BUYER PLAN | <input type="checkbox"/> | <input type="checkbox"/> |

MEDICARE SUPPLEMENT PLAN

For: Myself Dependents

- | | | |
|--|--------------------------|--------------------------|
| <input type="checkbox"/> ANTHEM BLUE CROSS III | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|

HMO PLANS

For: Myself Dependents

- | | | |
|---|--------------------------|--------------------------|
| <input type="checkbox"/> KAISER PERMANENTE | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> UNITEDHEALTHCARE (FORMERLY PACIFICARE) | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> CIGNA NETWORK MODEL PLAN | <input type="checkbox"/> | <input type="checkbox"/> |

MEDICARE MA-PD HMO PLANS

For: Myself Dependents

- | | | |
|---|--------------------------|--------------------------|
| <input type="checkbox"/> KAISER PERMANENTE SENIOR ADVANTAGE | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> SECURE HORIZONS by UNITEDHEALTHCARE | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> SCAN HEALTH PLAN | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> CIGNA MEDICARE SELECT PLUS RX
(IN MARICOPA COUNTY, ARIZONA ONLY.) | <input type="checkbox"/> | <input type="checkbox"/> |

LACERA – ADMINISTERED DENTAL/VISION PLANS (check one of the following boxes)

DENTAL/VISION PLANS

For: Myself Dependents

- | | | |
|--|--------------------------|--------------------------|
| <input type="checkbox"/> CIGNA INDEMNITY DENTAL/VISION | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> CIGNA DENTAL HMO/VISION | <input type="checkbox"/> | <input type="checkbox"/> |

REMEMBER: YOU MUST ENROLL IN A LACERA-ADMINISTERED MEDICAL AND/OR DENTAL/VISION PLAN WITHIN 60 DAYS FROM THE DATE OF YOUR RETIREMENT!
IF YOU MISS THIS DEADLINE, THE LATE ENROLLMENT RULES WILL APPLY.
THIS IS NOT AN ENROLLMENT FORM!

PEEL OFF THIS STRIP



NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES



BUSINESS REPLY MAIL

FIRST-CLASS MAIL PERMIT NO. 4706 PASADENA CA

POSTAGE WILL BE PAID BY ADDRESSEE

LACERA
PO BOX 7080
PASADENA CA 91109-8924

