BART RETIREE DENTAL AND VISION ELECTION FORM

You have a one-time only opportunity to elect BART Retiree Dental and/or Retiree Vision. The deadline to return the form is 30 days from the date the exit packet is mailed. Coverage is effective the first of the month following the last day of employment (no gap in coverage). **All costs are paid by the retiree.**

I _____wish to make an election:
Name of Retiree (print)

For dental, you can select only one plan, either Retiree Dental – Contracted Plan or Retiree Dental – Lower Premium Plan:

1a.**Retiree Dental – Contracted Plan** (same plan design as active employees) for **(check one only)**

☐ BART Retiree only	$100.89 per month ($99.73 Police)
☐ BART Retiree and one eligible dependent	$201.77 per month ($199.45 Police)
☐ BART Retiree and two or more eligible dependents	$302.66 per month ($299.20 Police)

IF YOU ARE RETIRING FROM BPOA/BPMA PLEASE CHECK HERE ☐ (POLICE RATES APPLY)

OR

1b.**Retiree Dental –Lower Premium Plan** (same plan for all groups) for **(check one only)**:

☐ BART Retiree only	$64.70 per month
☐ BART Retiree and one eligible dependent	$112.27 per month
☐ BART Retiree and two or more eligible dependents	$165.31 per month

For vision, you can select only one plan, either Retiree Basic Vision or Retiree Enhanced Vision.

2a.**Retiree Basic Vision** for **(check one only)**:

☐ BART Retiree only	$11.09 per month
☐ BART Retiree and one eligible dependent	$22.17 per month
☐ BART Retiree and two or more eligible dependents	$26.06 per month

OR

2b.**Retiree Enhanced Vision** for **(check one only):**

☐ BART Retiree only	$33.11 per month
☐ BART Retiree and one eligible dependent	$66.23 per month
☐ BART Retiree and two or more eligible dependents	$77.82 per month

Initial all the statements below in order for your election form to be processed:

_____I understand that I am enrolled in the Retiree Group and the cost of each plan may **decrease or increase based on participation, experience and market factors** in January of each year.

_____ I understand that the earliest I can cancel is the end of the calendar year in which retiree coverage begins and unless I submit a Notice of Retiree Dental and Vision Termination of Coverage form ("Termination Notice") prior to December 15th I will be **AUTOMATICALLY RENEWED FOR A ONE YEAR COMMITMENT** and will continue to be enrolled annually for a one year commitment until a Termination Notice is submitted.

_____ I understand that I cannot switch plans in the future.

_____I understand that if I terminate from the selected plan after completing my commitment period, I will no longer be eligible to participate in that plan.

_____I will mail payments to SF BART, PO BOX 884203, LOS ANGELES, CA 90088-4203 Add dental/vision amounts, make the check payable to BART and write your employee number on it.

Return Your Election Form to: benefits@bart.gov or BART Benefits, PO Box 12688, Oakland, CA 94604

Failure to submit the Election form or failure to make payments by the deadline will be considered a waiver of coverage and you will no longer be eligible to participate in the District's retiree dental and vision programs. First payment is due by the last day of the month after retirement and should be sent to SF BART, PO BOX 884203, LOS ANGELES, CA 90088-4203 (do NOT send enrollment forms to this address).

I also elect to enroll the following dependents:

Name of Dependent	Relationship	Birthdate	Check if dental elected	Check if vision elected

For any new dependents (not previously covered) provide documents supporting their eligibility. For previously covered dependents you must provide documents if requested. For a spouse or registered domestic partner, a marriage certificate or registration of domestic partnership. For a child, a copy of his/her birth certificate. For a child at least age 19 but under age 23, you will need to provide proof of full-time student status if you elected dental. For all dependents, a copy of their social security card must be on file or provided if requested.

I acknowledge and accept the terms and conditions for participation in the BART Retiree Dental and Vision Program.

_____

Signature of Retiree Date Employee ID Number

_____

Address Contact Phone Number