BEVERLY HILLS UNIFIED SCHOOL DISTRICT
OPEN ENROLLMENT FORM
RETIREES OVER 65 YEARS OLD
JANUARY 1, 2025 - DECEMBER 31, 2025

Name **Social Security Number** **Date of Birth**

Street Address **City** **Zip Code** **Phone Number**

email address (optional) _____

DENTAL COVERAGE

	Employee	Employee +1	Family	
DELTA DENTAL PPO (AB528)	$104.65	$189.27	$214.54	
			Dental Monthly Premium	

☐ *I do not want to make changes to my dental coverage*

VISION COVERAGE

	Employee	Employee +1	Family	
VISION SERVICE PLAN (VSP)	$7.36	$13.83	$20.43	
			Vision Monthly Premium	

☐ *I do not want to make changes to my vision coverage*

TOTAL COVERAGE CHOICES	

Note:

1. Dental and Vision - continuing Enrollment Only. Medical coverage is handled by CalPERS.
2. Payment for premiums are due on the 1st of the month or my be paid in advance.

Signature: _____ **DATE:** _____

Please list dependents to be covered. You will be required to pay for their coverage monthly in addition to the vision selection for all.

Name	Social Security Number Required	Relationship	Date of Birth	Dental	VSP