

**BEVERLY HILLS UNIFIED SCHOOL DISTRICT
OPEN ENROLLMENT FORM
RETIREES UNDER 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	\$51.52	\$105.73	\$152.42
Dental Monthly Premium			

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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			

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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. Dental and Vision premiums are paid and deducted from the district contribution cap.

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