KERN LEGACY
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Retiree Open Enrollment
PLAN YEAR 2027

Clear Form

Return completed form (front and back) to Kern County Health & Wellness by 5:00 p.m. on Friday, November 6, 2026

Effective Date: 01/01/2027

1. RETIREE/RETIREE BENEFICIARY/RENEGADE INFORMATION

LAST NAME	FIRST NAME	SSN OR SYSTEM ID
STREET ADDRESS, APT. OR SUITE NO., CITY, STATE, ZIP CODE		
TELEPHONE NUMBER	EMAIL	DATE OF BIRTH
DATE OF RETIREMENT	DEPARTMENT RETIRED FROM	GENDER (M/F)

OFFICE USE ONLY

Bargaining Unit: _____ ☐ RHPSP Elig ☐ Stipend Elig ☐ RHPSP Opt Out

Employee/System ID: _____

PP_____ $_____ PP_____ $_____

2. LIST ALL DEPENDENTS THAT YOU ARE ENROLLING: Complete ONLY if enrolling Dependents.

Be sure to attach a marriage certificate for a spouse, the certificate from the Secretary of State for a domestic partner, and birth certificates for all children you are enrolling. **Children 19, 20, 21, and 22: MUST** have previously been enrolled as your dependent and be enrolled in school full-time (12 or more units)—**student certification is required**.

	NAME (Last Name, First Name)	GENDER (M/F)	DATE OF BIRTH	SSN
Spouse				
Child				
Child				
Child				

3. OTHER INSURANCE INFORMATION: Complete ONLY if you or a Dependent who you are enrolling has Medicare or other Employer Group Health Insurance Coverage.

NAME OF COVERED SPOUSE/DEPENDENT	INSURANCE NAME AND GROUP NO.	EMPLOYER NAME	☐ Individual Coverage ☐ Family Coverage

Are you or any of dependent(s) listed in section 2 eligible for Medicare? ☐ **YES*** ☐ **NO**

***If YES, enter the name if the individual who is Medicare Eligible:**_____

Complete the Retiree Certification and Authorization for Release of Information & Payroll Deduction on the back of this form with original signatures. Failure to complete the back of this form will result in your request being rejected. For questions or assistance with completing this form, contact (661) 868-3182.

RETURN COMPLETED FORMS TO:

Kern County Health & Wellness

1115 Truxtun Avenue, 1st Floor, Bakersfield, CA 93301

RETIREE CERTIFICATION

_____ INITIAL — I have read and understand the eligibility policy and certify that any dependents listed on the attached enrollment form submitted (if applicable) are eligible.

_____ INITIAL — I understand that I may have dependents that are eligible for coverage that I have not listed on the attached enrollment form. By not listing them on this form I have chosen not to enroll them at this time. I waive my right to request enrollment for such dependents until either the next open enrollment or within the 30 days following a permitting event. I understand that open enrollment is not a guaranteed annual event.

_____ INITIAL — I understand that it is my responsibility to notify Kern County Health & Wellness of any changes in eligibility either for myself or my dependents. **I am aware that NO refunds of retiree premiums will be made if a dependent is not removed timely.**

_____ INITIAL — I understand that no retiree or their dependent is permitted to continue enrollment in any plan that is for participants under age 65 on or after the first day of the month in which they turn age 65.

_____ INITIAL — I understand that retiree medical plan coverage does not include dental nor vision coverage. If I wish to enroll in dental and vision, I will need to complete separate enrollment forms.

_____ INITIAL — I understand that I may disenroll at any time. If I do so, I may not re-enroll until the next open enrollment, and I will forfeit any County contribution toward my coverage.

_____ INITIAL — I understand that if a retiree or their dependent becomes eligible for Medicare due to a disability, they may continue to be enrolled in the Under 65 Health Plans until they reach age 65. Once the retiree or their dependent becomes eligible for Medicare, the County Self-funded plans **will only pay as a secondary plan when allowed by Medicare**.

I have read and understand the foregoing statements and the Kern County and Retiree health benefits eligibility policy. I certify under penalty of perjury under the laws of the State of California that all statements are true.

RETIREE/RETIREE BENEFICIARY

Signature_____ **Date**_____

AUTHORIZATION FOR RELEASE OF INFORMATION & PAYROLL DEDUCTION

- I hereby authorize the Kern County Health & Wellness to release, to exchange with and/or obtain from the Kern County Employees' Retirement Association and the County Department (or Special District) from which I retired any information necessary to process my request for retiree health coverage.
- I hereby authorize the County and the Kern County Employees' Retirement Association to make the necessary payroll deduction* from my pension check to pay for health benefits coverage for myself and my eligible, enrolled dependents.

* Once the premium exceeds the total County contribution amount, the retiree will pay the difference.

RETIREE/RETIREE BENEFICIARY

Signature_____ **Date**_____

RETURN COMPLETED FORMS BY 5:00 P.M. ON FRIDAY, NOVEMBER 6, 2026, TO:

Kern County Health & Wellness

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