



Retiree Open Enrollment
VISION SERVICE PLAN (VSP)
PLAN YEAR 2027

Clear Form

Return completed form 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)

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				

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. If I have eligible dependents but have not enrolled them by listing them on this form, I waive my right to request enrollment for such dependents until the next open enrollment or within 30 days of a permitting 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 if I choose to disenroll, I will not be eligible until the next open enrollment period. I agree that if I, or my dependents, seek services when not eligible for coverage, that I will pay the provider's usual fee.

INITIAL I understand that no dependent is permitted to continue coverage in this plan if I, as the retiree, cancel my participation.

INITIAL I hereby authorize Kern County Health & Wellness and KCERA to make the necessary payroll deduction from my pension check to pay for vision coverage for myself and my covered dependents. I authorize Kern County Health & Wellness, KCERA and my County department to release information to each other as necessary to process this request for retiree coverage.

RETIREE/RETIREE BENEFICIARY

Signature _____ Date _____

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

Kern County Health & Wellness
1115 Truxtun Avenue, 1st Floor, Bakersfield CA 93301