Association of Mendocino County Retired Employees Enrollment Form

For Office Use Only
Received
Effective Date

Step 1: Provide your information and authorize deduction. PLEASE PRINT CLEARLY.

Last Name		First Name		Full Social Security Number Required
Male/Female	Date of Birth	Telephone ( )	E-mail Address	
Home Address				
City		State	Zip	

I hereby authorize the Retirement Association to deduct the AMCRE monthly dues (currently $2) from my monthly retirement benefits for payment of membership dues to the Association of Mendocino County Retired Employees (AMCRE). I understand that this authorization will be in effect until revoked by myself, my surviving spouse and/or beneficiary, or another person that I have designated in writing to do so.

If electing voluntary benefits, I hereby authorize MCERA to deduct from my retirement benefit the current premiums and pay that amount to Pacific Group Agencies. Such deduction will continue until I notify Pacific Group Agencies in writing. I understand that there is a minimum one year commitment to the dental and vision plans and I acknowledge that I have read the Disclaimer in the benefit booklet.

Sign Here ➔ _____ **Date** _____

Step 2: If selecting spouse / domestic partner / family coverage, provide their information.

Spouse / Domestic Partner Name	Date of Birth	M / F	Full Social Security Number Required

Child Name *(Please note child coverage age limits. If disabled, please provide proof with enrollment.)*	Date of Birth	M / F	Full Social Security Number Required

Step 3: To enroll in the voluntary benefit plans, select the coverages that are right for you.

Dental

Who is covered (Select one):

- ☐ *Member Only*
- ☐ *Member + Child*
- ☐ *Member + Spouse*
- ☐ *Member + Family*

Vision

Who is covered (Select one):

- ☐ *Member Only*
- ☐ *Member + Spouse*
- ☐ *Member + Child*
- ☐ *Member + Family*

ID Shield

Who is covered (Select one):

- ☐ *Member Only*
- ☐ *Member + Spouse*

This plan requires an email address.

Personal Accident

Who is covered (Select one):

- ☐ *Member Only*
- ☐ *Member + Family*

Select AD&D Benefit Amount:

- ☐ $100,000
- ☐ $200,000
- ☐ $300,000
- ☐ $400,000
- ☐ $500,000

Provide beneficiary information:

Beneficiary: _____

Relationship:

Legal Shield

Plan covers member & family

- ☐ Member + Family

This plan requires an email address.

➔ **TURN OVER FOR ADDITIONAL PLAN INFORMATION** ➔

Armadillo Home Warranty	
Select Plan (Only select One): ☐ Appliance Plan ☐ Essentials Plus Plan	Property address, if differs from Step 1. Address _____ City _____ State _____ Zip _____

Step 4: For other plans, please see below.

Pet, Travel Guard, Emergency Assistance Plus, & Amplifon Hearing

Please refer to the Benefits Guide for information on enrolling in these plans.
If you need assistance, please call our Administrator, Pacific Group Agencies, at (800) 511-9065

Life Insurance

Rates listed in the Benefits Guide are estimates for an average healthy non-smoker. Final rate is determined by the Underwriter after reviewing your life insurance application and medical records.

Rates are approximately 100% higher for those with diabetes, heart disease, high cholesterol, or high blood pressure.

Rates are approximately 150% higher for healthy tobacco users. Tobacco users with other health issues will likely not qualify for coverage.

People actively treated for cancer, depression, heart attack, or stroke within the last two years will not qualify for coverage.

If you would like to be emailed an application for life insurance check here. ☐

If you have questions or need assistance in filling out these forms, call the Plan Administrator, Pacific Group Agencies, at (800) 511-9065.

Please mail this completed form in the enclosed postage paid envelope to: Pacific Group Agencies, Inc, 25876 The Old Road #11, Santa Clarita, CA 91381