



UNDER 65 RETIREE VISION INSURANCE REQUEST FORM
Coeur d'Alene School District #271

PLEASE PRINT

Name of Retiree _____ Male Female

Social Security Number _____ Birth date _____

Address _____
 (City) (State) (Zip Code)

Vision Tier: Employee (\$6.06), Employee + Spouse (\$12.13), Employee + Children (\$13.00), Employee + Family (\$20.74)

Dependents Name	Relationship	Date of Birth	Gender

Total Monthly Premium: _____

Date of Retirement _____ Coverage Paid by District through _____
 School Number and Address: Coeur d'Alene School District #271, 1400 N. Northwood Center Ct., Coeur d'Alene, ID 83814
 Signed-School District Office: _____

NOTE: Eligible Retirees must have Sick Leave Funds available through PERSI

Please pay my group vision insurance premium in the total amount shown above until my sick leave entitlement is exhausted. Rates, benefits, and eligibility of continued coverage of retirees are subject to the terms of the Group Policy issued to the School District by United Heritage Life Insurance Company.

The premium is subject to change. If the premium changes, I authorize the deduction of the premium amount.

I do not wish to continue coverage

Retiree Signature _____ Date _____

Approved by United Heritage Life Insurance Company:
 Date _____ Signature _____

This form is to be completed and signed by the School District Official, signed by the Retiree, sent to United Heritage Life Insurance Company, PO Box 7777; Meridian, ID 83680, and forwarded by United Heritage to PERSI.

United Heritage Life Insurance Company
 A United Heritage Financial Group Company

P.O. Box 7777, Meridian, ID 83680-7777 | (208) 493-6100 Toll Free (800) 657-6351 | unitedheritage.com