

**CITY OF RIVERSIDE SEIU UNIT REFUSE GROUP  
RETIREE HEALTH INSURANCE SUPPLEMENT AFFIDAVIT**

NAME: \_\_\_\_\_  
Last First MI

MAILING ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE #: ( \_\_\_\_\_ ) \_\_\_\_\_ LAST FOUR OF SSN #: \_\_\_\_\_

CITY OF RIVERSIDE DATES OF EMPLOYMENT: From \_\_\_\_\_ To \_\_\_\_\_  
(If there were breaks in employment, please list on reverse.)

RETIREMENT DATE: \_\_\_\_\_ JOB TITLE AT RETIREMENT: \_\_\_\_\_

WAS RETIREMENT DUE TO INDUSTRIAL INJURY?:  YES  NO

WHAT HEALTH PLAN ARE YOU COVERED BY?: \_\_\_\_\_

IS THIS YOUR PLAN, OR ARE YOU COVERED UNDER YOUR SPOUSE'S PLAN?: \_\_\_\_\_

DO YOU RECEIVE A MEDICARE SUPPLEMENT?:  YES  NO

INDICATE THE MONTHLY PREMIUM COST FOR YOURSELF ONLY: \$ \_\_\_\_\_

**\*\*Verification of monthly insurance premium must be submitted with this form\*\***

**Eligibility:**

- Retire from the City of Riverside and SEIU with 20 years of service with the General Unit PERC/SEIU Local 1997
- Industrial Disability – years of service and years of disability equal 20 years with a minimum of 5 years with the City of Riverside as an SEIU member
- Up to \$50 a month for retirement on or before 6/30/1990
- Up to \$100 a month for retirement after 6/30/1990

**\*Please note that health contributions are treated as Taxable Income; a W-2 form will be generated at the end of each calendar year.**

I understand that all Information is subject to verification. If additional information is required by the Committee, or received late, the processing of my payments may be delayed.

SIGNATURE : \_\_\_\_\_ DATE: \_\_\_\_\_

**FOR COMMITTEE USE ONLY:**

Approved: \_\_\_\_\_ AMT. \$ \_\_\_\_\_

Denied (Reason): \_\_\_\_\_