CITY OF RIVERSIDE SEIU UNIT GROUP HEALTH INSURANCE SUPPLEMENT AFFIDAVIT

NAME: ____
Last First MI

MAILING ADDRESS: ____

CITY: ____________________ STATE: __________ ZIP: ____________

PHONE #: (________)____________________ ID #:__________________

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

Only complete this section if you were employed with the City for less than twenty (20) years:

WERE YOU EVER EMPLOYED BY ANOTHER GOVERNMENTAL AGENCY?: ☐ YES ☐ NO

IF YES, LIST DATES AND NAMES OF EMPLOYERS INCLUDING MILITARY (MAY USE OTHER SIDE) :

EMPLOYER______________________________ DATES____________________________

EMPLOYER______________________________ DATES____________________________

EMPLOYER______________________________ DATES____________________________

WAS THE TIME WITH ANOTHER EMPLOYER COVERED BY P.E.R.S.?: ☐ YES ☐ NO

WHAT HEALTH PLAN ARE YOU COVERED BY?: ______________________________

DO YOU RECEIVE A MEDICARE SUPPLEMENT?: ☐ YES ☐ NO

MONTHLY PREMIUM COST FOR YOURSELF ONLY: $ ____________________________

IS THIS YOUR PLAN OR ARE YOU COVERED UNDER YOUR SPOUSE'S PLAN?: ______________

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.**

Verification of monthly insurance premium must be submitted with this form.

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): ____