

**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): _____