DEADLINE: MARCH 16, 2009 MEDICAL PLAN (circle one): KAISER EPO PPO

For office use only: Proof(s) received: RET____ SP__ New ___ Effective Date: _____ 2ND Notice_____

IMPORTANT: Medicare premium reimbursement is not automatically renewed each year unless the District's Human Resources Department receives your confirmation. All Retirees, Surviving Spouses and Eligible Dependents are **required** to submit a copy of Medicare Eligibility Confirmation Statement or Notice of Part B Premium Deduction to the District **annually**. NO RETROACTIVE PAYMENT will be made for late returns. This provision does not apply to retirees, surviving spouses and dependents who do not meet the minimum requirements set forth by Social Security Administration and Medicare.

FOOTHILL-DE ANZA COMMUNITY COLLEGE DISTRICT
2009 ANNUAL RETIREE SURVEY
for
PAID BENEFITS FOR RETIRED EMPLOYEES' PROGRAM

MANDATORY RESPONSE: PLEASE COMPLETE ALL SURVEY QUESTIONS REGARDLESS OF WHETHER YOU ARE ELIGIBLE FOR MEDICARE

RETIREE/SURVIVING SPOUSE NAME: _____SSN: _____ DATE OF BIRTH: _____

Please list ONLY insured dependents:

SPOUSE/DOMESTIC PARTNER NAME: _____ SSN: _____ DATE OF BIRTH: _____

PLEASE **CHECK** ONE IF YOUR SPOUSE/DOMESTIC PARTNER IS ALSO A DISTRICT RETIREE: YES_____ NO _____

OTHER DEPENDENTS: _____ SSN: _____ DATE OF BIRTH: _____

_____ SSN: _____ DATE OF BIRTH: _____

ADDRESS (IF DIFFERENT FROM ABOVE):

_____

CITY _____ STATE _____ ZIP CODE_____

TELEPHONE NUMBER: ( ) _____ - _____ E-MAIL ADDRESS: _____

DATE OF RETIREMENT (Employee Only): _____

Please **check** one: _____ Faculty Retiree _____ Classified Retiree _____ Retired Administrator

_____ Retired Trustee _____ Surviving Spouse

		Please **Circle**
1.	Are **you** presently covered by Medicare - Parts A & B?	YES or NO
	Does Medicare - Parts A & B, presently cover your spouse/Domestic Partner?	YES or NO
	Does Medicare - Parts A & B, presently cover your dependent(s)?	YES or NO

NOTE: IF **YES, please **ATTACH PROOF OF PREMIUM PAYMENT** to this form**

If you have already sent in your proof(s) of premium payment **prior** to receiving this survey, your proof(s) was received by Human Resources on:

_____ _____ _____
For Retiree only For Spouse only For Other Dependent(s)

2. If you will be eligible for Medicare Parts A & B in the future, please list **EXPECTED DATE OF ELIGIBILITY** below:
Fill in your 65th birthday **RETIREE** _____ **SPOUSE/DP** _____ **OTHER DEPENDENT** _____

3. How did you qualify for Medicare?

Please **check** one:

FOR RETIREE/SURVIVING SPOUSE

a. _____ AGE
b. _____ DISABILITY
c. _____ DISABLED BUT ACTIVELY AT WORK
d. _____ END STAGE RENAL DISEASE (ESRD)
e. _____ VIA SPOUSE SSN

Medicare Claim #: _____

Please **check** one:

FOR SPOUSE/DOMESTIC PARTNER

_____ AGE
_____ DISABILITY
_____ DISABLED BUT ACTIVELY AT WORK
_____ END STAGE RENAL DISEASE (ESRD)
_____ VIA SPOUSE SSN

Medicare Claim #: _____

(Note: Medicare Claim Number (AKA: Medicare HIC#) appears on your Medicare ID card, i.e. 123-45-6789A, B, or D)

(over)

4. If you are **not** eligible for Medicare, please check reason(s) why:

_____ Not old enough, please list current age_____.

_____ Lack of 40 minimum units required by Social Security Administration.

_____ Never contributed into social security system, therefore ineligible.

_____ Did not earn enough quarters with Social Security, however, will qualify for Medicare later when spouse turns 65.

_____ Other(s), please list reason(s)_____

***PLEASE SUBMIT SSA CERTIFICATION OF MEDICARE INELIGIBILITY STATUS**

5. Does another employer or any other retirement medical plan currently cover you or your spouse? (e.g. CHAMPUS, TRI-CARE)

⇒ Please list name(s) of insured: _____

⇒ Insurance name: _____ Policy Number: _____

If you, your spouse and/or other dependent(s) currently receive Medicare premium reimbursement from another employer, please list the source(s). You **can not** claim **dual reimbursement** from the District. If this applies to you, please do not include proof of Medicare payment to the District.

Name of Medicare Recipient: _____ Social Security Number_____

Relationship (please check one):

_____Self
_____Spouse/Domestic Partner
_____Other dependent(s)

Source(s) from which you currently receive reimbursement: _____

I do not wish to receive Medicare reimbursement from the Foothill-De Anza Community College District because I am currently receiving the same reimbursement from another employer.

_____ _____
Signature Date

ADDITIONAL COMMENTS AND/OR SUGGESTIONS:

I hereby certify that I am in compliance with the contractual requirements for eligibility for retiree benefits and that the information I have provided is correct.

RETIREE'S SIGNATURE: _____ DATE: _____

SPOUSE'S/DP's SIGNATURE: _____ DATE: _____

PLEASE FAX OR MAIL: (1) THE SURVEY, PROOF(S) OF MEDICARE PAYMENT, (2) COPY OF MEDICARE I.D. CARD(S) – THIS CARD IS REQUIRED FOR ALL NEW MEDICARE ELIGIBLE MEMBERS ONLY, AND/OR (3) SSA CERTIFICATION OF MEDICARE INELIGIBILITY STATUS TO:

FOOTHILL-DE ANZA COMMUNITY COLLEGE DISTRICT
ATTN: CHRSITINE VO, HR DEPT.
12345 EL MONTE RD
LOS ALTOS HILLS, CA 94022
FAX: (650) 949-2831 EMAIL: VoChristine@fhda.edu

NOTE: If you wish to receive a confirmation notice regarding your mailing to us, please send your mail via certified mail, or request confirmation via email to: HongLarry@fhda.edu. Unfortunately, due to limited resources, we cannot confirm by phone. Thank you.

cv-2/09