Foothill-De Anza Community College District

2011 RETIREE DATA UPDATE

for retirement benefits and medical provider correspondence

MANDATORY RESPONSE:

PLEASE COMPLETE ALL QUESTIONS REGARDLESS OF YOUR MEDICARE ELIGIBILITY

Every year Foothill-De Anza Community College District requests that all retirees update their personal information in order to keep our records accurate. **It is vital for the District to have correct contact information in order to keep you informed regarding any changes to medical benefits as negotiated with the bargaining units**. Contractually, you are required to notify the District ***within 10 business days*** for a change of address and **within 31 days** for a change of family status.

PLEASE FILL OUT THE ENTIRETY OF THIS FORM AND SUBMIT TO HUMAN RESOURCES *ALONG WITH* THE RETIREE MEDICARE SURVEY NO LATER THAN TUESDAY, MARCH 15, 2011.

PERSONAL INFORMATION

NAME: _____ SSN: _____ DATE OF BIRTH: _____

CURRENT STREET ADDRESS: _____

CITY _____ STATE _____ ZIP _____

HOME TELEPHONE NUMBER: ( ) _____ - _____

CELLULAR PHONE NUMBER: ( ) _____ - _____

E-MAIL: _____ DATE OF RETIREMENT: _____/_____/_____

PLEASE **CHECK ONE**: ☐ Faculty Retiree ☐ Classified Retiree ☐ Retired Administrator
☐ Retired Trustee ☐ Surviving Spouse

DEPENDENT INFORMATION (Please list ONLY *insured* dependents)

SPOUSE/SAME-SEX DOMESTIC PARTNER (DP)

NAME: _____ SSN: _____ DATE OF BIRTH: _____

PLEASE **CHECK BOX** IF YOUR SPOUSE/DP IS ALSO A DISTRICT RETIREE: ☐

DEPENDENT INFORMATION (continued)

OTHER INSURED CHILD DEPENDENTS

NAME: _____ SSN: _____ DATE OF BIRTH: _____

NAME: _____ SSN: _____ DATE OF BIRTH: _____

NAME: _____ SSN: _____ DATE OF BIRTH: _____

NAME: _____ SSN: _____ DATE OF BIRTH: _____

ALTERNATE CONTACT INFORMATION

DO YOU CURRENTLY HAVE A DESIGNATED POWER OF ATTORNEY (POA)? ☐ **YES** ☐ **NO**

If you have a Power of Attorney authorization form, please fax (650-949-2831) or mail a copy to the District to update your records as soon as possible.

Please note: **Due to HIPAA regulations, we are unable to discuss your private health information or anything benefits-related with anyone who is not designated as your Power of Attorney (POA).**

PLEASE LIST TWO (2) ALTERNATE CONTACTS IN THE EVENT WE ARE UNABLE TO CONTACT YOU FOR ANY REASON:

1) ALTERNATE CONTACT:

NAME: _____ RELATIONSHIP: _____

STREET ADDRESS: _____

CITY _____ STATE _____ ZIP _____

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

2) ALTERNATE CONTACT:

NAME: _____ RELATIONSHIP: _____

STREET ADDRESS: _____

CITY _____ STATE _____ ZIP _____

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

SUBMIT THIS FORM TO HUMAN RESOURCES *ALONG WITH* THE RETIREE MEDICARE SURVEY NO LATER THAN TUESDAY, MARCH 15, 2011.