REQUEST TO CHANGE BENEFIT PLAN FORM
for
RETIREES ONLY

FOOTHILL-DE ANZA
Community College District

IMPORTANT: COMPLETE THIS FORM *ONLY IF*
YOU WISH TO CHANGE MEDICAL PLANS OR DELETE/ADD DEPENDENT(S).

FOR 2011/2012, RETIREES ARE ***DEFAULTED*** TO THE CURRENT PLAN AND LEVEL OF COVERAGES; **DO NOT COMPLETE THE FORM *IF YOU WANT TO RETAIN*** THE SAME BENEFITS AND LEVEL OF COVERAGE!

If you wish to change plan or level of coverage, please make your selection for the Plan Year 2010/2011 (July 2011 – June 2012) below.

Circle the option to change your current benefit coverage:

	FROM	TO
Option #1	KAISER HMO	EPO Medical Plan
Option #2	KAISER HMO	PPO Medical Plan
Option #3	PPO Medical Plan	EPO Medical Plan
Option #4	PPO Medical Plan	KAISER HMO
Option #5	EPO Medical Plan	PPO Medical Plan
Option #6	EPO Medical Plan	KAISER HMO
Option #8	KAISER HMO	*WAIVE (Evidence of other coverage is **NOT** required)
Option #9	EPO Medical Plan	*WAIVE (Evidence of other coverage is **NOT** required)
Option #10	PPO Medical Plan	*WAIVE (Evidence of other coverage is **NOT** required)

***Note:** When you choose the option to "WAIVE" benefits for PY 11/12, your coverage provided by the district will cease as of **June 30, 2011** for the following benefits: Medical/Rx, Dental, Vision and Medicare Part B Premium reimbursement. Special open enrollment (reinstatement) is permitted **only if** you incur an IRS life-qualifying event (i.e., marriage, death, change in dependents' status or loss of other coverage).

The effective date of medical coverage for all changes made during this Open Enrollment will be July 1, 2011.

RETIREE NAME: _____ SSN_____ DOB: _____

SPOUSE NAME: _____ SSN_____ DOB: _____

OTHER DEPENDENT:_____ SSN_____ DOB: _____

MAILING ADDRESS: _____

_____

PHONE: _____ EMAIL ADDRESS: _____

_____ _____
Retiree Signature Date

Effective July 1, 2011: Retirees who are insured under **ANY** district-sponsored health plans, regardless of coverage level, are ***required*** to pay for their monthly premium contributions by arranging for electronic fund transfers via **ACH** process with **UnitedHealthcare Benefit Services**. Personal check and online payment options are no longer accepted. This applies to **retired** members in *both* Kaiser (HMO) and UnitedHealthcare (EPO/PPO/OOA). See enclosed material for rates.

DEADLINE: Return the form to the District by Friday, April 29, 2011 @ 5:00pm

Mail your form to:

Foothill - De Anza Community College District
Attn: BENEFITS UNIT
12345 El Monte Rd
Los Altos Hills, CA 94022
Fax # (650) 949-2831
Pdf/email to: MyBenefits@fhda.edu

Do NOT turn in this form if you wish to keep the same benefits plan and dependent coverage level as last year.