Form 1

Foothill-De Anza Community College District
2012 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 THURSDAY, MARCH 15, 2012.

PERSONAL INFORMATION

Name	
ADDRESS	

SSN: _____ DATE OF BIRTH: _____DATE OF RETIREMENT: _____/_____/_____

HOME TELEPHONE NUMBER: ( ) _____ - _____

CELLULAR PHONE NUMBER: ( ) _____ - _____

E-MAIL: _____

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/SAME SEX DP IS ALSO A DISTRICT RETIREE: ☐

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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.

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 THURSDAY, MARCH 15, 2012.

DEADLINE: MARCH 15, 2012 MEDICAL PLAN (circle one): KAISER EPO PPO OOA **Form 2**

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

Foothill-De Anza Community College District
2012 ANNUAL RETIREE SURVEY
for Paid Benefits for Retired Employees' Program

MANDATORY RESPONSE:

PLEASE COMPLETE ALL SURVEY QUESTIONS REGARDLESS OF YOUR MEDICARE ELIGIBILITY

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.

Name	**Is this address correct?**
ADDRESS	☐ **YES** ☐ **NO** ***If incorrect, please correct below.***

SSN: _____

ADDRESS: _____ **APT/UNIT #** _____

CITY: _____ **STATE:** _____

ZIP: _____ **Home Phone:** _____

Date of Retirement (for District Retiree listed above ONLY):	____/____/____

I am a (check one):

☐ Faculty Retiree ☐ Classified/Staff Retiree ☐ Retired Administrator ☐ Retired Trustee ☐ Surviving Spouse

List other dependents *currently insured* on the District benefits plan:

Relationship	**Name**	**SSN**	**DOB** *(mm/dd/yyyy)*	**District Retiree?**
Spouse/DP		_____-_____-_____	/ /	☐ YES ☐ NO

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Other Dependent		_____-_____ -_____	/ /	☐ YES	☐ NO
Other Dependent		_____-_____ -_____	/ /	☐ YES	☐ NO

Medicare Information (Please check *YES* or *NO*):		
Are **you** presently covered by Medicare – Parts A & B?	☐ YES	☐ NO
Is **your spouse or domestic partner** presently covered by Medicare – Parts A & B?	☐ YES	☐ NO
Are **your dependent(s)** presently covered by Medicare – Parts A & B?	☐ YES	☐ NO

If you *not presently covered, skip the next section.*

If you are presently covered **by Medicare, how do you qualify?**

*Please check **ONE** option only.*

	RETIREE / SURVIVING SPOUSE		**SPOUSE / SAME-SEX DOMESTIC PARTNER**
☐	Age	☐	Age
☐	Disability	☐	Disability
☐	Disabled but actively at work	☐	Disabled but actively at work
☐	End Stage Renal Disease (ESRD)	☐	End Stage Renal Disease (ESRD)
☐	Via Spouse's Eligibility (social security number)	☐	Via Spouse's Eligibility (social security number)
Medicare Claim #*:		**Medicare Claim #*:**	

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

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If eligible: SUBMIT PROOF OF MEDICARE PAYMENT(S) WITH THESE FORMS. See insert for accepted documentation.

IF you have already sent in your proof(s) of premium payment prior to receiving the survey, your proof(s) was/were received by HR on:	
For Retiree only _____ **For Spouse/DP only** _____ **For Other Dependent (s)** _____	.

DEADLINE: MARCH 15, 2012 MEDICAL PLAN (circle one): KAISER EPO PPO OOA **Form 2**

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If you or any of your currently insured dependents *are not presently eligible* for Medicare Parts A & B, please list EXPECTED DATE OF ELIGIBILITY *(65th birthday)* **and check a reason below: *(If eligible, skip section.)***

YOU*	____/____/____	**SPOUSE/ DOMESTIC PARTNER**	____/____/____	**OTHER DEPENDENT**	____/____/____

If *you are not presently eligible for Medicare Parts A & B, please indicate the reasons below** *(check **ALL** that apply)*:

- ☐ Not old enough. 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. Will qualify for Medicare later when spouse turns 65.
- ☐ Other Reason: _____

***PLEASE SUBMIT SOCIAL SECURITY CERTIFICATION OF MEDICARE INELIGIBILITY STATUS**

Other Medical Coverage (Please check *YES* or *NO*):

1) Does another employer or any other retirement medical plan currently cover you or your spouse or other dependent? *(e.g. CHAMPUS, TRI-CARE)* ☐ YES ☐ NO

If ***YES***, please provide the following information:

NAME OF INSURED: _____INSURANCE NAME: _____

POLICY NUMBER: _____

2) Does you, your spouse or other dependent(s) currently receive Medicare premium reimbursement from another employer?

Please note: You (or your dependents) cannot claim dual Medicare reimbursement from the District. If your answer is "YES", do not provide proof for Medicare reimbursement for these individuals. ☐ YES ☐ NO

If ***YES***, please list the source(s) and certify below. *(If NO, skip to next section)*:

NAME OF MEDICARE REIMBURSEMENT RECIPIENT(S):

_____

SOCIAL SECURITY NUMBERS(S): _____ SOURCE(S): _____

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:

RETIREE's SIGNATURE: _____ DATE: _____

SPOUSE/DP's SIGNATURE: _____ DATE: _____

DEADLINE: MARCH 15, 2012 MEDICAL PLAN (circle one): KAISER EPO PPO OOA **Form 2**
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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: _____

SUBMIT THIS FORM TO HUMAN RESOURCES *ALONG WITH* THE (1) RETIREE DATA UPDATE, (2) PROOF(S) OF MEDICARE PAYMENT, (3) COPY OF MEDICARE I.D. CARD(S)—*if applicable—new Medicare-eligible members only*, **and (4) SSA CERTIFICATION OF MEDICARE INELIGIBILITY STATUS**—*if applicable* **BY DEADLINE: THURSDAY, MARCH 15, 2012.**

To receive Quarterly Medicare reimbursement for the First Quarter 2012 (January –March), or **April 15, 2012**, your proofs of Medicare Part B payment must be received by March 15, 2012. Late notices received by the District between March 16-31, 2012 will be processed along with the second quarter refund (April-June) or July 15, 2012. The above rule is enforced for current qualified Medicare recipients only. Newly qualified members effective date of reimbursement is based on their dates of qualification, and date of notice received. For example, if you are newly eligible for Medicare effective March 1, 2012, and we received your documentation on April 20, 2012, then you have missed the one-month of premium reimbursement, the effective date of Medicare reimbursement in this case is April 1, 2012. Hence, it is important that you meet the deadline to avoid any delay in payment.

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: BENEFITS UNIT

12345 EL MONTE RD

LOS ALTOS HILLS, CA 94022

FAX: (650) 949-2831 EMAIL: MyBenefits@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: **MyBenefits@fhda.edu, please allow 48-72 hours for a reply)**. Unfortunately, due to limited resources, we cannot confirm by phone. Thank you.

cv-2/12