Foothill-De Anza Community College District

2013 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.

Current Address:

NAME: _____ **IN CARE OF** *(optional)*: _____

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

CITY: _____ **STATE:** _____ **ZIP:** _____

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		_____-____ -_____	/ /	☐ YES ☐ NO
Other Dependent #1		_____-____ -_____	/ /	☐ YES ☐ NO
Other Dependent #2		_____-____ -_____	/ /	☐ 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 other dependent(s)** presently covered by Medicare – Parts A & B?	☐ YES ☐ NO

If you *are presently covered* by Medicare, how do you qualify? ***(If not presently covered, skip section.)***
*Please check **ONE** option only.*

RETIREE / SURVIVING SPOUSE		SPOUSE / 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***)

If you or any of your currently insured dependents *are presently ineligible* for Medicare Parts A & B, please list FUTURE EXPECTED DATE OF ELIGIBILITY *(65th birthday)*: ***(If eligible, skip section.)***

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

If *you* are not presently eligible for Medicare Parts A & B, please indicate the reason(s) 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** *(for all applicable persons)*

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: _____

NAME OF INSURED: _____ INSURANCE NAME: _____ POLICY NUMBER: _____

2) Do you, your spouse or other dependent(s) currently receive Medicare premium reimbursement from another employer? ☐ YES ☐ NO

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.

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

NAME OF MEDICARE REIMBURSEMENT RECIPENT(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:

SIGNATURE: _____ DATE: _____

SIGNATURE: _____ DATE: _____

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 complete and correct.

RETIREE'S SIGNATURE: _____ DATE: _____

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

SUBMIT THIS FORM TO HUMAN RESOURCES *ALONG WITH* THE (1) PROOF(S) OF MEDICARE PAYMENT, (2) COPY OF MEDICARE I.D. CARD(S)*—if applicable—new Medicare-eligible members only*, and (3) SSA CERTIFICATION OF MEDICARE INELIGIBILITY STATUS***—if applicable—new Medicare-eligible members only***

NO LATER THAN FRIDAY, MARCH 15, 2013.

MAIL: ATTN: Benefits Unit, 12345 El Monte Road, Los Altos Hills, CA **FAX:** (650) 949-2831

RECEIPT CONFIRMATION REQUESTS *taken via email ONLY—no phone calls, please*: **MyBenefits@fhda.edu**