

Foothill- De Anza Community College District  
**2014 ANNUAL RETIREE SURVEY**  
For Paid Benefits for Retired Employee's 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 Benefits Department receives your confirmation. All retirees 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, and dependents who do not meet the minimum requirements set forth by Social Security Administration and Medicare.

**PERSONAL INFORMATION**

NAME: _____	DOB: _____	DOH: _____
SSN (Last 4 digits): _____	CWID: _____	CalPERS ID: _____
<b>ADDRESS</b>		<b>Is this address correct?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO  <i>If incorrect, please correct below.</i>

NEW HOME ADDRESS: \_\_\_\_\_ APT/UNIT # \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

HOME PHONE NUMBER: \_\_\_\_\_ CELLULAR PHONE NUMBER: \_\_\_\_\_

PERSONAL EMAIL: \_\_\_\_\_

Date of Retirement (for District Retiree listed above ONLY): _____
CLASSIFICATION:
MEDICAL PLAN NAME:

LN: \_\_\_\_\_

FN: \_\_\_\_\_

CWID: \_\_\_\_\_

List other dependents <b>currently insured</b> on the District benefits plan:				
Relationship	Name	SSN	DOB (MM/DD/YYYY)	District Retiree?
Spouse/DP		____-____-____	____/____/____	<input type="checkbox"/> YES <input type="checkbox"/> NO
O Dependent		____-____-____	____/____/____	<input type="checkbox"/> YES <input type="checkbox"/> NO
Other Dependent		____-____-____	____/____/____	<input type="checkbox"/> YES <input type="checkbox"/> NO

## MEDICARE INFORMATION

Medicare Information (Please check <b>YES</b> or <b>NO</b> ):			
Are <b>you</b> presently covered by Medicare – Parts A & B?			<input type="checkbox"/> YES <input type="checkbox"/> NO
Is <b>your spouse or same-sex domestic partner</b> presently covered by Medicare – Parts A & B?			<input type="checkbox"/> YES <input type="checkbox"/> NO
Are <b>your other dependent(s)</b> presently covered by Medicare – Parts A & B?			<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>If you <u>are presently covered</u> by Medicare, how do you qualify? (If <u>not presently covered</u>, skip section.)</b> Please check <b>ONE</b> option only.			
RETIREE / SURVIVING SPOUSE		SPOUSE / DOMESTIC PARTNER	
<input type="checkbox"/>	Age	<input type="checkbox"/>	Age
<input type="checkbox"/>	Disability	<input type="checkbox"/>	Disability
<input type="checkbox"/>	Disabled but actively at work	<input type="checkbox"/>	Disabled but actively at work
<input type="checkbox"/>	End Stage Renal Disease (ESRD)	<input type="checkbox"/>	End Stage Renal Disease (ESRD)
<input type="checkbox"/>	Via Spouse's Eligibility (social security number)	<input type="checkbox"/>	Via Spouse's Eligibility (social security number)
Medicare Claim #*:		Medicare Claim #*:	

\*Claim Number (aka **Medicare HIC #**) appears on your Medicare ID card. i.e., 123-45-6789A, B, or D  
**If eligible: PLEASE SUBMIT PROOF OF MEDICARE PAYMENT(S) WITH THESE FORMS. See Insert for accepted documentations.**

If you have already sent in your proof(s) of premium payment prior to receiving the survey, your proof(s) was/were received by the Benefits Unit on:	
For Retiree only _____	For Spouse/DP only _____

LN: \_\_\_\_\_

FN: \_\_\_\_\_

CWID: \_\_\_\_\_

Are <b>you</b> currently covered by Medicare – Parts A & B?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Is <b>your Spouse/DP</b> currently covered by Medicare – Parts A & B?	<input type="checkbox"/> YES <input type="checkbox"/> NO

If you or any of your currently insured dependents <b>are not currently eligible</b> for Medicare Parts A & B, please list FUTURE EXPECTED DATE OF ELIGIBILITY (65th birthday) and check a reason below: (If <b>eligible</b> , skip section.)					
<b>YOU*</b>	____/____/____	<b>**SPOUSE/DP</b>	____/____/____	<b>OTHER DEPENDENT</b>	____/____/____
If <b>you*</b> and or your <b>Spouse/DP**</b> are not presently eligible for Medicare Parts A & B, please indicate the reasons below (check <b>ALL</b> that apply):					
<input type="checkbox"/> Not old enough. List current age: _____ <input type="checkbox"/> Lack of 40 minimum units required by Social Security Administration. <input type="checkbox"/> Never contributed into social security system, therefore ineligible. <input type="checkbox"/> Did not earn enough quarters with Social Security. Will qualify for Medicare later when spouse turns 65. <input type="checkbox"/> Other Reason: _____					
<b>*PLEASE SUBMIT A CURRENT "2014" SOCIAL SECURITY CERTIFICATION OF MEDICARE INELIGIBILITY STATUS (If applicable)</b>					

I hereby certify that I am in compliance with the contractual requirements for eligibility for retiree benefits. I further understand that I am not receiving any reimbursement for Medicare Part B premium from any other source. I attest by signing below that the information provided is true and accurate with no omissions or misstatements.

SIGNATURE OF RETIREE: \_\_\_\_\_

DATE: \_\_\_\_\_

SIGNATURE OF SPOUSE/DP: \_\_\_\_\_

DATE: \_\_\_\_\_

PLEASE FAX OR MAIL THIS FORM TO THE BENEFITS UNIT **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**—if applicable **BY DEADLINE: MONDAY, MARCH 17, 2014 TO:**

FOOTHILL-DE ANZA COMMUNITY COLLEGE DISTRICT

ATTN: BENEFITS UNIT

12345 EL MONTE RD.

LOS ALTOS HILLS, CA 94022

**FAX:** (650) 949-6299 **EMAIL:** [MyBenefits@fhda.edu](mailto:MyBenefits@fhda.edu)

IMPORTANT: Due to limited resources, receipt confirmation requests taken via email ONLY – no phone calls, please email to: [MyBenefits@fhda.edu](mailto:MyBenefits@fhda.edu) (please allow 48-72 hours after documentation is received for a reply). If you wish to receive a confirmation notice regarding your mailing to us, please send your mail via certified mail. Thank you.