OFFICE USE: Proof(s) received: RET_____ SPOUSE/DP_____ NEW_____ Effective Date: _____2nd Notice_____

Foothill- De Anza Community College District

2018 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: _____

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

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

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

HOME PHONE NUMBER: _____ **MOBILE PHONE NUMBER:** _____

PERSONAL EMAIL: _____

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

LN: _____ FN: _____ CWID: _____

List other dependents *currently insured* on the District benefits plan:				
Relationship	**Name**	**SSN**	**DOB** *(MM/DD/YYYY)*	**District Retiree?**
Spouse/DP		_____-_____ -_____	____/____/____	☐ YES ☐ NO
Other Dependent		_____-_____ -_____	____/____/____	☐ YES ☐ NO
Other Dependent		_____-_____ -_____	____/____/____	☐ YES ☐ NO

MEDICARE INFORMATION

Medicare Information (Please check *YES* or *NO*):	
Are **you** presently covered by covered by Medicare – Parts A & B?	☐ YES ☐ NO
Is **your spouse or same-sex 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 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 **you** presently receiving social security pension?	☐ YES ☐ NO
Is **your Spouse/DP** presently receiving social security pension?	☐ YES ☐ NO

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

YOU*	____/____/____	****SPOUSE/ DP**	____/____/____	**OTHER DEPENDENT**	____/____/____

If *you and or your Spouse/DP** 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 A CURRENT "2018" SOCIAL SECURITY CERTIFICATION OF MEDICARE INELIGIBILITY STATUS (*If applicable*)**

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: THURSDAY, MARCH 15, 2018 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

IMPORTANT: Due to limited resources, *receipt confirmation requests* taken via email ONLY – no phone calls, please email to: MyBenefits@fhda.edu (please allow up to 72 hours after documentation is received by the District 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.