LOS ANGELES COMMUNITY COLLEGE DISTRICT

Vested _____%

Application for Retiree Health Benefits Enrollment

1. Personal Information

Last Name, First Name, MI | *Emp Num* | *Social Security Number* | *Date of Birth*

Street Address (no P.O. Boxes) | *Your Home Phone* | *Retiree Contact Name*

City *State* *Zip* | *Your Cell or Alternate Phone* | *Phone # for Retiree Contact*

Status:

☐ Married ☐ Divorced ☐ Widowed
☐ Domestic Partnered ☐ Single

Email Address

2. Retirement Information

Resignation Date: _____ Retirement Date: _____

Retirement System: ☐ CalSTRS ☐ CalPERS

Bargaining Unit: ☐ 99, SEIU Operations ☐ 721, Supervisory (Class) ☐ 911, Teamsters
☐ 1521, AFT Faculty ☐ 1521A, AFT Classified ☐ Building, Construction Trades
☐ Unclaimed ☐ Unrepresented

Medicare Coverage: **District Board Rule 101701.12.a requires that all eligible retirees and their dependents age 65 or be enrolled in parts of Medicare for which they are eligible. Medicare Part A (Hospital Insurance) is required only if the retiree/dependent is eligible for premium-free Part A coverage as determined by Social Security Administration or is eligible for coverage at no cost to the retiree under a plan which pays the Part A premium on behalf of the retiree. Medicare Part B (Medical Insurance) is required for all retirees and dependents. The monthly premium for Part B shall be the responsibility of the retiree/dependent.**

Medicare A Date Effective | *Medicare B Date Effective* | *Medicare Claim Number*

Do you have or are you eligible for other insurance coverage? ☐ Yes ☐ No

If Yes, name of insurance carrier: _____

Group #: _____ Policy #: _____

Address: _____ Telephone #: _____

City *State* *Zip*

3. Dependent Information OR ☐ No Dependents

SPOUSE'S INFORMATION

Last Name, First Name, MI | *Social Security Number* | *Date of Birth*

Medicare A Date Effective | *Medicare B Date Effective* | *Medicare Claim Number*

Does your spouse have or are you eligible for other insurance coverage? ☐ Yes ☐ No

If Yes, name of insurance carrier: _____

Group #: _____ Policy #: _____

Address: _____ Telephone #: _____

City *State* *Zip*

OTHER DEPENDENT INFORMATION

Last Name, First Name, MI | Gender | Last Name, First Name, MI | Gender

Soc. Sec. Number | Date of Birth | Soc. Sec. Number | Date of Birth

Relationship | Relationship

Please enroll me and/or my eligible dependents in the following plans.

This medical election is for:

☐ **Me**	☐ **PERS Care PPO**	☐ **Blue Shield Access +**
☐ **Me and my eligible dependents**	☐ **PERS Choice PPO**	☐ **Blue Shield Net Value**
	☐ **PERS Select PPO**	☐ **Kaiser Permanente**

If you are switching health plans from what you had when you were an active employee, you must ***also*** submit the "**Health Benefits Plan Enrollment for Retirees form**". LACCD will fax it to CalPERS.

The PPO plans may be used inside of California as well as outside of California or the U.S. These plans are administered by Anthem Blue Cross.

PERS Care is a comprehensive plan (90/10 Coverage) used in conjunction with Medicare. If one or all family members is/are not on Medicare, you should contact the LACCD Health Benefits Unit to get an understanding of how this plan will affect your retirement income.

The Blue Shield HMO plan can be used outside of California or the U.S. in ***emergency situations only***. Contact Blue Shield for more information on this restriction.

If you live within 30 miles of a Kaiser facility in California, Colorado, Georgia, Hawaii, Maryland, Ohio, Oregon, Virginia, Washington or Washington D.C you may choose a Kaiser option.

This dental election is for:

☐ **Me**	☐ **Delta Dental PPO**	☐ **MetLife (Safeguard) HMO**
☐ **Me and my eligible dependents**		

This vision election is for:

☐ **Me**
☐ **Me and my eligible dependents**

I understand that the elections I make on this form will remain in effect as long as I am eligible or until I make another election during Open Enrollment. I hereby authorize any insurance company, organization, employer, physician, surgeon, pharmacist or other health care provider to release any information requested to pay any claim under the plan(s) I have elected. I am enrolling myself (or refusing coverage) and those eligible dependents I have listed on the Application for Retiree Health Benefits Form for coverage under the plan(s) I have elected. I understand that I am responsible for reporting any change(s) in the eligibility status of my dependents. I also understand that the benefits and services of the plan(s) I elected are coordinated with those provided by any other group hospital, medical or dental benefit or service plan. I understand that I must abide by the provisions of the plan(s) I have elected and that any controversy or discrepancy between any plan member and such plan(s) (including its agents, staff physicians, employees and providers) is subject to binding arbitration. By signing this form below, I certify that I understand the benefits options available to me and accept full responsibility for my elections. I also certify that the information and documentation I have provided are true and accurate to the best of my knowledge.

_____ _____

Signature **Date**

Note: For Life Insurance Coverage, you may convert the District paid to an individual policy for which you will be responsible for the premium by completing the life conversion form within 31 days from date of your resignation. A representative from the Metropolitan Life Insurance Company will contact you regarding your options for conversion.

HEALTH BENEFITS UNIT USE ONLY		
Benefits Eligibility Date:	☐ **Not Vested**	
Vesting Requirement:	**VESTED:**	**50% 75% 100%**
Paperwork Processed By:		

LACCD Form C896 Revised 3/24/2011: CH