LOS ANGELES COMMUNITY COLLEGE DISTRICT

Application for Continuation of Health Benefits for Survivors

I wish to apply for the continuation of health benefits as the surviving spouse/domestic partner and/or eligible dependent(s) of a deceased employee or retiree. I have previously been covered as the spouse or dependent of the employee or retiree indicated below.

1. Employee/Retiree Information (include certificate of death)

Name	*SSN*	*Date of Birth*	*Date of Death*

2. Personal Information (Spouse, Domestic Partner, Eligible Dependent)

Last	*First*	*MI*	*Social Security Number*	*Date of Birth*

Street Address (no P.O. Boxes)	*Your Home Phone*	*Your Cell or Alternate Phone*

City	*State*	*Zip*	*Email Address*

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

3. Retiree Contact: Someone who will always be able to get into contact with you.

Last	*First*	*MI*	*Telephone Number*

Address	*Email Address*

City	*State*	*Zip*

4. Medical Plan

Medical plan enrollment must be approved and processed by CalPERS. You may contact them at (888) 225 – 7377.

5. Dental Plan

☐ Delta Dental PPO
☐ MetLife Dental HMO (formerly Safeguard)

Coverage Type
☐ Survivor only
☐ Survivor + one
☐ Survivor + Family

6. Vision Plan

☐ Vision Service Plan

Coverage Type
☐ Survivor only
☐ Survivor + one
☐ Survivor + Family

(OVER)

NAME: _____ SSN: | | | | | | | | | |

7. Enrollment Information (other than self)

Enrollee	Add	Delete	Name (Last on top line, First, MI)	Gender	Birth Date	Soc. Security #
Relationship to Employee/Retiree	☐ Dental ☐ Vision	☐ Dental ☐ Vision				
Relationship to Employee/Retiree	☐ Dental ☐ Vision	☐ Dental ☐ Vision				
Relationship to Employee/Retiree	☐ Dental ☐ Vision	☐ Dental ☐ Vision				

8. Certify and Submit this Enrollment/Change Form

_____ ***initial*** I certify that I am an annuitant inheriting my late spouse's pension. I continue to receive a monthly pension allotment.

_____ ***initial*** I certify that the employee/retiree and I were ***not*** divorced, marriage annulled or dissolved, or that our domestic partnership was ***not*** terminated, annulled, or dissolved, at the time of his/her passing.

_____ ***initial*** ***I understand that I am responsible for reporting any change(s) in the eligibility status of my dependents within 60 days***. Further, if I fail to report status changes within 60 days, I understand that I could be liable for retroactive premium payments in excess of the amount of my plan if I had reported the change in time, and I further understand that I could be liable for medical expenses incurred by the ineligible party.

_____ ***initial*** 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 annual enrollment. I am enrolling for myself and those eligible dependents that I have listed in Part 6 of this form for coverage under the plan(s) I have selected.

_____ ***initial*** I 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.

_____ ***initial*** I 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.

_____ ***initial*** 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.

_____ ***initial*** I have received a copy of Board Rule (101700, Health Benefit Group coverage for survivors).

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 that I have provided are true and accurate to the best of my knowledge.

X _____ _____

Signature ***Date***

Send this form and the original certificate of death to:

LACCD Health Benefits Call Center
770 Wilshire Blvd., 6th Floor
Los Angeles, CA 90017
(888) 428-2980