LOS ANGELES COMMUNITY COLLEGE DISTRICT

Application for Retiree Health Benefits

1. Name (Last, First, MI)		
2. Employee #	3. Social Security #	
4. Marital Status M ☐ S ☐	5. Date of Birth (MM/DD/YYYY)	6. Gender M ☐ F ☐
7. Job Title		
8. Street Address		
9. City, State, Zip		
10. Daytime Telephone ( )	11. E-mail Address	
12. Resignation Date (MM/DD/YYYY)	13. Retirement Date (MM/DD/YYYY)	

14. Retirement System (Pls check one) STRS ☐ PERS ☐

15. Last work location? City ☐ District Office ☐ East ☐ Harbor ☐ Mission ☐ Pierce ☐ Southwest ☐ Trade –Technical ☐ Valley ☐ West ☐

16. What was your bargaining unit affiliation when you retired?
Technical/Clerical ☐ Maint/Operations ☐ Crafts ☐ Police ☐ Faculty ☐
Management ☐ Supervisory ☐ Teamsters ☐ Unclaimed ☐ Confidential ☐

17. Medicare Coverage (Board rule 101701.12.a) Medicare Part A ☐ Medicare Part B ☐

What is the effective date listed on your Medicare card? (MM/DD/YYYY)

District Board Rule 101701.12.a require all eligible retirees and their dependents age 65 or over must 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.

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

If Yes, name of insurance carrier:	
Group #	Policy #
Address	Telephone ( )

19. Provide the name of someone outside your household who will always know how to contact you.

Name	
Relationship	Telephone ( )

DEPENDENT INFORMATION

Please list dependent/s who are currently covered under your current enrollment .

SPOUSE'S INFORMATION

20. Name (Last, First, MI)		
21. Social Security #	22. Date of Birth (MM/DD/YYYY)	23. Gender M ☐ F ☐
24. Medicare Coverage (Board rule 101701.12. a)	Medicare Part A ☐	Medicare Part B ☐
What is the effective date listed on their Medicare card? (MM/DD/YYYY)		
25. Does your Spouse have or is eligible for other group health insurance coverage?	Yes ☐	No ☐
If yes, name of insurance carrier:		
Group #	Policy #	
Address	Telephone ( )	

OTHER DEPENDENT'S INFORMATION

26. Name (Last, First, MI)	27. Relationship	
28. Social Security #	29. Date of Birth (MM/DD/YYYY)	30. Gender M ☐ F ☐

OTHER DEPENDENT'S INFORMATION

31. Name (Last, First, MI)	32. Relationship	
33. Social Security #	34. Date of Birth (MM/DD/YYYY)	35. Gender M ☐ F ☐

34. Please enroll me and/or my eligible dependents in the following plans. (You and/or your eligible dependents are only eligible to enroll in the plans which you are currently enrolled as a dependent.)

This medical election is for:

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

- ☐ **PERS Care PPO**
- ☐ **PERS Choice PPO**
- ☐ **PERS Select PPO**
- ☐ **Blue Shield HMO**
- ☐ **Kaiser**

You must ***also*** submit the "**Health Benefits Plan Enrollment for Retirees form**" (attached) directly to CalPERS using the enclosed paperwork.

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.

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

- ☐ **Delta Dental PPO**
- ☐ **Safeguard HMO**

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.

Your 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.

FOR HEALTH INSURANCE SECTION USE ONLY		
Vesting Requirement		
Benefit Eligibility Date	Assignment	Approval
Deleted From Active Group	Ceridian Data Entry	By:
Effective Date for Retiree Group	Retiree Letter	Transmittal
LACCD Form C896-10 2/07		

Revised 1/07/2010: CH

Health Benefits Plan Enrollment for Retirees

888 CalPERS (or **888**-225-7377) • TTY for speech and hearing impaired: (916) 795-3240 • Fax (916) 795-1277

For Retirees only. (Active employees — contact your Personnel Office).

To save time, complete this form before you request changes over the phone.

Section 1 — Type of Change

Check the type of change you are making.

- ☐ Change My Health Plan
- ☐ Enroll in a Health Plan (Complete all sections.)
- ☐ Add Eligible Dependents to My Health Plan
  (Complete Retiree Information, Dependent Information, and Retiree Signature.)

During Open Enrollment, you can make health plan changes by calling **888 CalPERS** (or **888**-225-7377), by faxing this form to us at (916) 795-1277, or by visiting my|CalPERS at http://my.calpers.ca.gov.

Section 2 — Retiree Information

Be sure to include the name of the agency from which you retired.

If you are enrolled in Medicare, please send a copy of your Medicare card.

Name (First Name, Middle Initial, Last Name) ____ Social Security Number ___ – ___ – ___

Birthdate (mm/dd/yyyy) ____ Gender ____ Daytime Phone ( ) ____ Evening Phone ( ) ____

Address ____ County (residence) ____

City ____ State ____ ZIP ____

Retirement Date (mm/dd/yyyy) ____ Name of Former Employer ____

Section 3 — Health Plan

Before requesting a plan change, verify that the doctor you want is contracted with the health plan and is accepting new patients. If not, you will need to find another doctor who contracts with the new plan.

Name of New Health Plan ____ Name of Doctor/Medical Group (include ID#s, if known) ____

Section 4 — Dependent Information

All dependents currently enrolled on your health plan will remain on your plan.

List only the dependents you are adding. If you have more than 3 dependents, please include on a separate page.

Dependent Name ____ Social Security Number ___ – ___ – ___ Birthdate (mm/dd/yyyy) ____

Relationship ____ Gender ____ Doctor or Medical Group ____

Dependent Name ____ Social Security Number ___ – ___ – ___ Birthdate (mm/dd/yyyy) ____

Relationship ____ Gender ____ Doctor or Medical Group ____

Dependent Name ____ Social Security Number ___ – ___ – ___ Birthdate (mm/dd/yyyy) ____

Relationship ____ Gender ____ Doctor or Medical Group ____

Put your name and Social Security number at the top of every page.

Your Name | Social Security Number

Section 5

Retiree Signature

Please be sure to sign this form.

By signing this form, I elect to change to the plan indicated above and/or add eligible family members. I also certify that the health information listed above is true and complete and authorize deductions, if applicable, to be made from my retirement allowance to cover my share of the health plan premium.

Signature of Retiree | Date

Section 6

Additional Information

You can submit your health plan changes by mail, by phone, or by fax.

After making changes to your health plan, be sure to examine your retirement check to verify that the proper deduction was made. If the deduction is incorrect, call CalPERS to report the discrepancy.

Health Benefits Plan Enrollment for Retirees

Use this form to enroll in a health plan, change your plan, or add an eligible dependent(s) to your plan. All changes are subject to verification of eligibility. You are eligible to enroll in a CalPERS health plan if you meet all of the following requirements:

- Are eligible for enrollment on the date of separation
- Retired within 120 days from the day you separated from your job
- Are receiving a retirement check

Contact CalPERS with any eligibility questions.

Notes

- Any health plan changes made during Open Enrollment become effective the following January 1.
- You can use this form to make changes to your health plan outside of Open Enrollment due to a qualifying life event, such as adding a new spouse, registered domestic partner, or economically dependent child.
  - Adding a spouse requires a copy of your marriage license.
  - Adding a registered domestic partner requires a copy of the approved *Declaration of Domestic Partnership*.
  - Adding an economically dependent child requires an ***Affidavit of Eligibility*** form (HBD-35).
- Be sure to report changes to CalPERS in a timely manner to avoid retroactive reimbursement liability.
- If you are enrolled in a Medicare Managed Care plan (Medicare Advantage) and are switching to a Supplement to Medicare plan, you must contact your current health plan or the nearest Social Security Administration office to disenroll your Medicare benefits from your current Medicare Managed Care plan. If you do not disenroll, Medicare will not pay for services you receive under your new health plan.
- If any one of your dependents is enrolled in Medicare, please send a copy of the Medicare card.

Mail to: **Office of Employer & Member Health Services** • P.O. Box 942714, Sacramento, CA 94229-2714