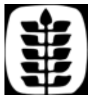

LOS ANGELES COMMUNITY COLLEGE DISTRICT

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 ☐

This medical election is for:

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

- ☐ **Blue Shield PPO**
- ☐ **Blue Shield HMO**
- ☐ **Kaiser Permanente**

For Kaiser Permanente enrollees age 65 and over with Medicare Part A and/or B, LACCD requires that you enroll in Kaiser Permanente Senior Advantage (KPSA). Please complete a KPSA Election form prior to retirement date. The form may be obtained from LACCD, Health Insurance Section.

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		