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Retiree Election Change Form/Eligibility Questionnaire

Please read the enclosed enrollment information carefully, and make your 2009 benefit elections below. **YOU MUST MAKE A MEDICAL AND DENTAL PLAN ELECTION FOR 2009, EVEN IF YOU ARE NOT MAKING A CHANGE.** If you have questions or need assistance, please contact the LACCD Health Benefits Call Center at (888) 428-2980 between 9:00 a.m. and 4:00 p.m., Monday through Friday.

1. Choose Your Medical Plan for 2009:

- Blue Shield PPO Plan
- Blue Shield HMO Plan – *If you are not currently enrolled in this plan, please complete #6 below*
- Kaiser Permanente HMO

2. Choose Your Dental Plan for 2009:

- Delta Dental PPO Plan
- Safeguard HMO Plan – *If you are not currently enrolled in this plan, please complete #6 below*

3. Complete and sign the Medicare eligibility questionnaire on the back of this form.

4. Update your emergency contact information. Name: _____ Phone: _____

5. OPTIONAL: Add or Drop Dependent Coverage

Note: Only complete this section if you want to CHANGE your current dependent coverage now.

Add	Delete	Name (Last, First, MI)	Sex	Birth Date	Social Security #
<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision				
<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision				

6. Enter HMO Provider Information

If you are changing your coverage to the Blue Shield HMO medical plan or the SafeGuard HMO dental plan, you must fill out this section. Enter the primary care physician or primary care dentist information for each enrollee. The provider ID number and name can be found in the provider directory at www.blueshieldca.com or www.safeguard.net.

Note: Only complete this section if you are SWITCHING TO an HMO medical or dental plan now.

	Enter provider name and ID # of Blue Shield physician	Enter provider name and ID # of SafeGuard dentist
Self		
<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner		
Child		

Please complete the questionnaire on the back. You must sign this form and return it to LACCD in the in the envelope included with your annual enrollment packet, NO LATER THAN NOVEMBER 26, 2008.

Eligibility Questionnaire

District Board rules state that all retirees/survivors age 65 and over, and their eligible dependents age 65 and over, must be enrolled in Medicare Parts A & B in order to continue their District health insurance coverage.

Retiree/Survivor Medicare Information

Circle Your Answer

- | | | |
|--|-----|----|
| 1. Are you age 65 or older (or eligible for Medicare due to disability)?
<i>If YES, answer the questions below. If NO, skip this section.</i> | YES | NO |
| 2. Are you currently enrolled in Medicare Part A? | YES | NO |
| 3. Are you currently enrolled in Medicare Part B? | YES | NO |

Spouse/Domestic Partner Medicare Information

Circle Your Answer

- | | | |
|--|-----|----|
| 1. Is your spouse/domestic partner age 65 or older (or eligible for Medicare due to disability)?
<i>If YES, answer the questions below. If NO, skip this section.</i> | YES | NO |
| 2. Is your spouse/domestic partner currently enrolled in Medicare Part A? | YES | NO |
| 3. Is your spouse/domestic partner currently enrolled in Medicare Part B? | YES | NO |

Dependent Children Information

Circle Your Answer

- | | | |
|---|-----|----|
| 1. Is your dependent child age 19 or older?
<i>If YES, answer the questions below. If NO, skip this section.</i> | YES | NO |
| 2. Is your dependent child who is age 19 or older a full-time student?* | YES | NO |
| 3. Is your dependent child who is age 19 or older disabled? | YES | NO |
| 4. Has your dependent child who is age 19 or older gotten married since the last annual enrollment period? | YES | NO |

*Attach proof of full-time student status, such as a copy of an official class schedule or a signed statement from the Registrar or Dean of Students indicating full-time status.

Survivor Marital Status Information

Circle Your Answer

- | | | |
|---|-----|----|
| Have you remarried or entered into a domestic partner relationship since the last annual enrollment period? | YES | NO |
|---|-----|----|

By signing this form below, I certify that I have read and understand the statements and declarations made herein. I declare under penalty of perjury, under the laws of the State of California, that the information and documentation I have provided above are true and accurate to the best of my knowledge.

Retiree/Survivor Signature

Date

Questions? Please call the LACCD Health Benefits Call Center at (888) 428-2980.