



# LOS ANGELES COMMUNITY COLLEGE DISTRICT

## Application for Retiree Health Benefits

1. Name (Last, First, MI)		
2. Employee #	3. Social Security #	
4. Marital Status M <input type="checkbox"/> S <input type="checkbox"/>	5. Date of Birth (MM/DD/YYYY)	6. Gender M <input type="checkbox"/> F <input type="checkbox"/>
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 <input type="checkbox"/> PERS <input type="checkbox"/>		
15. Last work location? City <input type="checkbox"/> District Office <input type="checkbox"/> East <input type="checkbox"/> Harbor <input type="checkbox"/> Mission <input type="checkbox"/> Pierce <input type="checkbox"/> Southwest <input type="checkbox"/> Trade-Technical <input type="checkbox"/> Valley <input type="checkbox"/> West <input type="checkbox"/>		
16. What was your bargaining unit affiliation when you retired? Technical/Clerical <input type="checkbox"/> Maint/Operations <input type="checkbox"/> Crafts <input type="checkbox"/> Police <input type="checkbox"/> Faculty <input type="checkbox"/> Management <input type="checkbox"/> Supervisory <input type="checkbox"/> Teamsters <input type="checkbox"/> Unclaimed <input type="checkbox"/> Confidential <input type="checkbox"/>		
17. Medicare Coverage (Board rule 101701.12.a) Medicare Part A <input type="checkbox"/> Medicare Part B <input type="checkbox"/>		
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 <input type="checkbox"/> No <input type="checkbox"/>		
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 ( )	
<b>DEPENDENT INFORMATION</b>		
Please list dependent/s who are currently covered under your current enrollment .		
<b>SPOUSE'S INFORMATION</b>		
20. Name (Last, First, MI)		
21. Social Security #	22. Date of Birth (MM/DD/YYYY)	23. Gender M <input type="checkbox"/> F <input type="checkbox"/>
24. Medicare Coverage (Board rule 101701.12. a) Medicare Part A <input type="checkbox"/> Medicare Part B <input type="checkbox"/>		
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 <input type="checkbox"/> No <input type="checkbox"/>		
If yes, name of insurance carrier:		
Group #	Policy #	
Address		Telephone ( )
<b>OTHER DEPENDENT'S INFORMATION</b>		
26. Name (Last, First, MI)		27. Relationship
28. Social Security #	29. Date of Birth (MM/DD/YYYY)	30. Gender M <input type="checkbox"/> F <input type="checkbox"/>
<b>OTHER DEPENDENT'S INFORMATION</b>		
31. Name (Last, First, MI)		32. Relationship
33. Social Security #	34. Date of Birth (MM/DD/YYYY)	35. Gender M <input type="checkbox"/> F <input type="checkbox"/>

**This medical election is for:**

- Me  Blue Cross Prudent Buyer (PPO)  
 Me and my eligible dependents  Blue Cross 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  Blue Cross Dental Net  Blue Cross Dental  
Option 1 (HMO) Option 2 (PPO)  
 Me and my eligible dependents  Safeguard

**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. Please complete and return the life conversion form included in this packet to the address listed on the back of the form.**

<b>FOR HEALTH INSURANCE SECTION USE ONLY</b>		
<b>Vesting Requirement</b>		
<b>Benefit Eligibility Date</b>	<b>Assignment</b>	<b>Approval</b>
<b>Deleted From Active Group</b>	<b>Sylinq Data Entry</b>	<b>By:</b>
<b>Effective Date for Retiree Group</b>	<b>Retiree Letter</b>	<b>Transmittal</b>
<b>LACCD Form C896-10 9/03</b>		