LOS ANGELES COMMUNITY COLLEGE DISTRICT

Health Benefits Use

Vested _____%

Application for Retiree Health Benefits Enrollment

1. Personal Information

Last Name, First Name, MI | *Emp Num* | *Social Security Number* | *Date of Birth*

Street Address (no P.O. Boxes) | *Your Home Phone* | *Retiree Contact Name*

City *State* *Zip* | *Your Cell or Alternate Phone* | *Phone # for Retiree Contact*

Status:

☐ Married/Partnered ☐ Single

Email Address

2. Retirement Information

Resignation Date: _____ Retirement Date: _____

Retirement System: ☐ CalSTRS ☐ CalPERS

Bargaining Unit: ☐ 99, SEIU Operations ☐ 721, Supervisory (Class) ☐ 911, Teamsters
☐ 1521, AFT Faculty ☐ 1521A, AFT Classified ☐ Building, Construction Trades
☐ Unclaimed ☐ Unrepresented

Medicare Coverage: **District Board Rule 101701.12.a requires that all eligible retirees and their dependents age 65 and over be enrolled in parts of Medicare for which they are eligible. Medicare Part A (Hospital Insurance)** is required 1) If the retiree/dependent is eligible for premium-free Part A coverage as determined by Social Security Administration or 2) Is eligible for coverage at no cost to the retiree under a plan which pays the Part A premium on behalf of the retiree. If the employee chose not to have Medicare deductions taken during the Medicare election of 2001, they must have Medicare A at their expense. **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.

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

3. Dependent Information OR ☐ No Dependents

SPOUSE'S INFORMATION

Last Name, First Name, MI | *Social Security Number* | *Date of Birth*

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

OTHER DEPENDENT INFORMATION: If you have more than two other dependents please attach additional pages.

Last Name, First Name, MI | Gender | Last Name, First Name, MI | Gender

Soc. Sec. Number | Date of Birth | Soc. Sec. Number | Date of Birth

Relationship | Relationship

MEDICAL

PPO (Anthem Blue Cross)	***HMO***	***HMO, part 2***
☐ PERS Care	☐ Anthem Select	☐ Health Net Salud & Mas
☐ PERS Choice	☐ Anthem Traditional	☐ Kaiser Permanente
☐ PERS Select	☐ Blue Shield Access Plus	☐ Sharp
	☐ Health Net Smart Care	☐ United Healthcare

If you are switching health plans from what you had when you were an active employee, you must ***also*** submit the **Health Benefits Plan Enrollment for Retirees form (HBD-30)**. LACCD will fax it to CalPERS.

The PPO plans may be used inside of California as well as outside of California, or the U.S. In order to use a plan outside of the US, you must pay out-of-pocket and submit a claim for reimbursement.

The HMOs plan can be used outside of California or the U.S. in ***emergencies only***. Contact the HMO 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.

DENTAL

☐ Delta Dental (PPO)
☐ Safeguard (HMO)

VISION

☐ VSP

Life Insurance

You may convert the District paid life insurance to an individual policy for which you will be responsible for the premium. A representative from CIGNA Life Insurance Company will contact you regarding your options for conversion.

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 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.

_____ _____

Signature **Date**

Submit Form To**:**

Email: healthbenefits@email.laccd.edu
Fax: (213) 891 - 2008

HEALTH BENEFITS UNIT USE ONLY

Benefits Eligibility Date:	☐	**Not Vested**
Vesting Requirement:	**VESTED:**	**50% 75% 100%**
Paperwork Processed By:		

LACCD Form C896 Revised March 27, 2017: CH