Foothill-De Anza Community College District

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**2017 ANNUAL RETIREE SURVEY**

For Paid Benefits for Retired Employee’s Program

**2012 ANNUAL RETIREE SURVEY**

for Paid Benefits for Retired Employees’ Program

**MANDATORY RESPONSE:
PLEASE COMPLETE ALL SURVEY QUESTIONS REGARDLESS OF YOUR MEDICARE ELIGIBILITY**

IMPORTANT: Medicare premium reimbursement is not automatically renewed each year unless the District’s Human Resources Benefits Department receives your confirmation. All retirees and Eligible Dependents are required to submit a copy of Medicare Eligibility Confirmation Statement or Notice of Part B Premium Deduction to the District annually. NO RETROACTIVE PAYMENT will be made for late returns. This provision does not apply to retirees, and dependents who do not meet the minimum requirements set forth by Social Security Administration and Medicare.

**PERSONAL INFORMATION**

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| --- |
|  NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN (Last 4 digits): \_\_\_\_\_\_\_\_\_\_\_\_\_ CWID: \_\_\_\_\_\_\_\_\_\_\_ CalPERS ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ADDRESS | Is this address correct?🞏 YES 🞏 NO*If incorrect, pleasecorrect below.* |

NEW HOME ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ APT/UNIT # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE: \_\_\_\_\_\_\_\_\_\_\_\_ ZIP CODE: \_\_\_\_\_\_\_\_\_\_\_\_\_

HOME PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MOBILE PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PERSONAL EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Date of Retirement (for District Retiree listed above ONLY):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **CLASSIFICATION:** |
| **MEDICAL PLAN NAME:**  |

|  |
| --- |
| **List other dependents *currently insured* on the District benefits plan:** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Relationship** |  **Name** | **SSN** | **DOB** *(MM/DD/YYYY)* |  **District Retiree?** |
| Spouse/DP |  | **\_\_\_\_\_\_-\_\_\_\_\_ -\_\_\_\_\_** | **\_\_\_\_/\_\_\_\_/\_\_\_\_** | 🞏 YES 🞏 NO  |
| Other Dependent |  | **\_\_\_\_\_\_-\_\_\_\_\_ -\_\_\_\_\_\_** | **\_\_\_\_/\_\_\_\_/\_\_\_\_** | 🞏 YES 🞏 NO  |
| Other Dependent |  | **\_\_\_\_\_\_-\_\_\_\_\_ -\_\_\_\_\_\_** | **\_\_\_\_/\_\_\_\_/\_\_\_\_** | 🞏 YES 🞏 NO  |

**MEDICARE INFORMATION**

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| --- |
| **Medicare Information (Please check *YES* or *NO*):** |
| Are **you** presently covered by covered by Medicare – Parts A & B? | 🞏 YES 🞏 NO  |
| Is **your spouse or same-sex domestic partner** presently covered by Medicare – Parts A & B? | 🞏 YES 🞏 NO  |
| Are **your other dependent(s)** presently covered by Medicare – Parts A & B? | 🞏 YES 🞏 NO  |
| **If you *are presently covered* by Medicare, how do you qualify? *(If not presently covered, skip section.)****Please check* ***ONE*** *option only.* |
| **RETIREE / SURVIVING SPOUSE** | **SPOUSE / DOMESTIC PARTNER** |
| 🞏 | Age | 🞏 | Age |
| 🞏 | Disability | 🞏 | Disability |
| 🞏 | Disabled but actively at work | 🞏 | Disabled but actively at work |
| 🞏 | End Stage Renal Disease (ESRD) | 🞏 | End Stage Renal Disease (ESRD) |
| 🞏 | Via Spouse’s Eligibility (social security number) | 🞏 | Via Spouse’s Eligibility (social security number) |
| **Medicare Claim #\*:** |  | **Medicare Claim #\*:** |  |

\*Claim Number (aka **Medicare HIC #**) appears on your Medicare ID card. i.e., *123-45-6789****A***, **B**, or **D**

**If eligible: PLEASE SUBMIT PROOF OF MEDICARE PAYMENT(S) WITH THESE FORMS. See Insert for accepted documentations.**

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| **If you have already sent in your proof(s) of premium payment prior to receiving the survey, your proof(s) was/were received by the Benefits Unit on:**For **Retiree only\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For Spouse/DP only \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  |

|  |  |
| --- | --- |
| Are **you** presently receiving social security pension? | 🞏 YES 🞏 NO  |
| Is **your Spouse/DP** presently receiving social security pension? | 🞏 YES 🞏 NO  |

|  |
| --- |
| **If you or any of your currently insured dependents *are not presently eligible* for Medicare Parts A & B, please list FUTURE EXPECTED DATE OF ELIGIBILITY** *(65th birthday)***and check a reason below: *(If eligible, skip section.)*** |
| **YOU\*** | **\_\_\_\_\_/\_\_\_\_/\_\_\_\_\_** | **\*\*SPOUSE/DP** | **\_\_\_\_\_/\_\_\_\_/\_\_\_\_\_** | **OTHER DEPENDENT** | **\_\_\_\_\_/\_\_\_\_/\_\_\_\_** |
| **If *you\* and or your* Spouse/DP\*\*are not presently eligible for Medicare Parts A & B, please indicate the reasons below** *(check* ***ALL*** *that apply)***:**  |
| 🞏 | Not old enough. List current age: **\_\_\_\_\_\_\_** |
| 🞏 | Lack of 40 minimum units required by Social Security Administration. |
| 🞏 | Never contributed into social security system, therefore ineligible. |
| 🞏 | Did not earn enough quarters with Social Security. Will qualify for Medicare later when spouse turns 65. |
| 🞏 | Other Reason: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **\*PLEASE SUBMIT A CURRENT “2017” SOCIAL SECURITY CERTIFICATION OF MEDICARE INELIGIBILITY STATUS (*If applicable*)** |

**I hereby certify that I am in compliance with the contractual requirements for eligibility for retiree benefits. I further understand that I am not receiving any reimbursement for Medicare Part B premium from any other source. I attest by signing below that the information provided is true and accurate with no omissions or misstatements.**

 **SIGNATURE OF RETIREE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SIGNATURE OF SPOUSE/DP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PLEASE FAX OR MAIL THIS FORM TO THE BENEFITS UNIT *ALONG WITH* THE (1) PROOF(S) OF MEDICARE PAYMENT, (2) COPY OF MEDICARE I.D. CARD(S)**—*if applicable—new Medicare-eligible members only***, AND (3) SSA CERTIFICATION OF MEDICARE INELIGIBILITY**—*if applicable* **BY DEADLINE: WEDNESDAY, MARCH 15, 2017 TO:**

 **FOOTHILL-DE ANZA COMMUNITY COLLEGE DISTRICT**

**ATTN: BENEFITS UNIT**

**12345 EL MONTE RD.**

**LOS ALTOS HILLS, CA 94022**

**FAX: (650) 949-6299 EMAIL:** **MyBenefits@fhda.edu**

IMPORTANT: Due to limited resources, *receipt confirmation requests* taken via email ONLY – no phone calls, please email to: MyBenefits@fhda.edu (please allow up to 72 hours after documentation is received by the District for a reply). If you wish to receive a confirmation notice regarding your mailing to us, please send your mail via certified mail. Thank you.