

Foothill- De Anza Community College District
2020 ANNUAL RETIREE SURVEY
For Paid Benefits for Retired Employee's 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

NAME: _____	DOB: _____	DOH: _____
SSN (Last 4 digits): _____	CWID: _____	CalPERS ID: _____
ADDRESS		Is this address correct? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If incorrect, please correct below.</i>

NEW HOME ADDRESS: _____ **APT/UNIT #** _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

HOME PHONE NUMBER: _____ **MOBILE PHONE NUMBER:** _____

PERSONAL EMAIL: _____

Date of Retirement (for District Retiree listed above ONLY): _____
CLASSIFICATION:
MEDICAL PLAN NAME:

LN: _____

FN: _____

CWID: _____

List other dependents currently insured on the District benefits plan:				
Relationship	Name	SSN	DOB (MM/DD/YYYY)	District Retiree?
Spouse/DP		____-____-____	___/___/___	<input type="checkbox"/> YES <input type="checkbox"/> NO
Other Dependent		____-____-____	___/___/___	<input type="checkbox"/> YES <input type="checkbox"/> NO
Other Dependent		____-____-____	___/___/___	<input type="checkbox"/> YES <input type="checkbox"/> NO

MEDICARE INFORMATION

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

*Claim Number (aka **Medicare HIC #**) appears on your Medicare ID card. i.e., 123-45-6789A, B, or D
If eligible: PLEASE SUBMIT PROOF OF MEDICARE PAYMENT(S) WITH THESE FORMS. See Insert for accepted documentations.

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 _____

LN: _____

FN: _____

CWID: _____

Are you presently receiving social security pension?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Is your Spouse/DP presently receiving social security pension?	<input type="checkbox"/> YES <input type="checkbox"/> 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	____/____/____
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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 "2020" 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: **TUESDAY, MARCH 31, 2020 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.

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