LN: _____ FN: _____ CWID:_____

PERSONAL INFORMATION

Foothill-De Anza Community College District

2022 MEDICARE PART B REIMBURSEMENT PROJECT

For Paid Benefits for Retired Employee's

PLEASE COMPLETE THIS FORM ONLY IF YOU ARE EXPERIENCING A LIFE QUALIFYING EVENT SUCH AS MEDICARE-ELIGIBLE FOR THE FIRST TIME, REINSTATEMENT OF MEDICARE ENROLLMENT, REPORTING DEATH OF A DEPENDENT AND/OR CHANGE OF ADDRESS/PHONE/EMAIL.

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.

NAME:_____ SSN (Last 4 digits): _____ Date of Birth: _____Date of Hire: _____	
NEW ADDRESS:	**Is this a change of address** ☐ **YES** ☐ **NO** ***Enter new address to the left***

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

PERSONAL EMAIL: _____

For HR to use only

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

LN: _____ FN: _____ CWID:_____

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

I hereby certify that I am in compliance with the contractual requirements for eligibility of retiree benefit. 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 PDF/EMAIL TO MyBenefits@fhda.edu, FAX OR MAIL THIS FORM TO THE BENEFITS UNIT ALONG WITH THE FOLLOWING: (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: THURSDAY, MARCH 31, 2022 TO:**

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 3 business days) after documentation is received by the District for a reply.

For fax receipt, please allow up to 5-7 business days as the District Office is closed due to COVID-19 and the staff is available to pick up mail only twice a week.

To receive a confirmation notice regarding your mailing to us, please send your mail via certified mail. Thank you.