

CWID: \_\_\_\_\_ Name: \_\_\_\_\_ Level of Coverage: \_\_\_\_\_ Doc. Receipt Date: \_\_\_\_\_

**FOOTHILL-DE ANZA COMMUNITY COLLEGE DISTRICT**

**2026 Retiree Survey**

**IMPORTANT:** Medicare premium reimbursement is not automatically renewed each year. Retirees and eligible dependents must submit proof of Medicare premium payment to the district annually. **NO RETROACTIVE PAYMENT** will be processed for late submissions. 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): _____ Medical Plan _____	
Date of Birth: _____ Date of Hire: _____ Date of Retirement: _____	
Current Address: _____	
<b><u>New Address:</u></b> _____	Is there a change of address <input type="checkbox"/> YES <input type="checkbox"/> NO Enter new address to the left

PHONE NUMBER: \_\_\_\_\_ PERSONAL EMAIL: \_\_\_\_\_

EMERGENCY CONTACT NAME: \_\_\_\_\_ EMERGENCY CONTACT PHONE NUMBER: \_\_\_\_\_

EMERGENCY CONTACT EMAIL: \_\_\_\_\_

Please return the completed form to the Benefits Unit by email, or fax, or US mail by the deadline: **Friday, March 13, 2026.**

Due to limited resources, all receipt confirmation requests will be taken via email ONLY – no phone calls. Please allow up to 5 business days after the documentation is received for a response.

*I hereby certify that I am in compliance with the contractual requirements for the eligibility of 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: \_\_\_\_\_

**FOOTHILL-DE ANZA COMMUNITY COLLEGE DISTRICT  
ATTN: BENEFITS UNIT  
12345 EL MONTE RD.  
LOS ALTOS HILLS, CA 94022**