CWID:_____ LN:_____ Medical Plan:_____ Level of Coverage:_____ Doc. Receipt Date:_____

FOOTHILL-DE ANZA COMMUNITY COLLEGE DISTRICT

2024 Retiree Survey

IMPORTANT: Medicare premium reimbursement is not automatically renewed each year. 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 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:	
New Address:	**Is there a change of address** **☐ YES ☐ 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 along with the following: (1) Proof(s) of Medicare premium payment, (2) Copy of Medicare I.D. card(s) (for *new Medicare-eligible members only)*, and (3) SSA certification of Medicare ineligibility (*if applicable)* by the deadline: **Friday, March 15, 2024.**

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 documentations are 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:_____

Signature of Spouse/DP: _____ Date:_____

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