

Foothill-De Anza Community College District
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 Department receives your confirmation. All Retirees, Surviving Spouses 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, surviving spouses and dependents who do not meet the minimum requirements set forth by Social Security Administration and Medicare.

Name	Is this address correct?
ADDRESS	<input type="checkbox"/> YES <input type="checkbox"/> NO <i>If incorrect, please correct below.</i>

SSN: _____

ADDRESS: _____ APT/UNIT # _____

CITY: _____ STATE: _____

ZIP: _____ Home Phone: _____

Date of Retirement (for District Retiree listed above ONLY):	_____/_____/_____
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I am a (check one):
 Faculty Retiree Classified/Staff Retiree Retired Administrator Retired Trustee Surviving Spouse

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

For office use only: Proof(s) received: RET___ SP___ New ___ Effective Date: _____ 2ND Notice _____

Other Dependent		____-____-____	/ /	<input type="checkbox"/> YES <input type="checkbox"/> NO
Other Dependent		____-____-____	/ /	<input type="checkbox"/> YES <input type="checkbox"/> NO

Medicare Information (Please check YES or NO):			
Are you presently covered by Medicare – Parts A & B?			<input type="checkbox"/> YES <input type="checkbox"/> NO
Is your spouse or domestic partner presently covered by Medicare – Parts A & B?			<input type="checkbox"/> YES <input type="checkbox"/> NO
Are your dependent(s) presently covered by Medicare – Parts A & B?			<input type="checkbox"/> YES <input type="checkbox"/> NO
If you <i>not</i> presently covered, skip the next section.			
<i>If you are presently covered</i> by Medicare, how do you qualify?			
<i>Please check ONE option only.</i>			
RETIREE / SURVIVING SPOUSE		SPOUSE / SAME-SEX 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: SUBMIT PROOF OF MEDICARE PAYMENT(S) WITH THESE FORMS. See insert for accepted documentation.

IF you have already sent in your proof(s) of premium payment prior to receiving the survey, your proof(s) was/were received by HR on:	
For Retiree only	_____
For Spouse/DP only	_____
For Other Dependent (s)	_____

If you or any of your currently insured dependents **are not presently eligible** for Medicare Parts A & B, please list **EXPECTED DATE OF ELIGIBILITY** (65th birthday) and check a reason below: (If **eligible**, skip section.)

YOU*	____/____/____	SPOUSE/ DOMESTIC PARTNER	____/____/____	OTHER DEPENDENT	____/____/____ -
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If **you*** 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 SOCIAL SECURITY CERTIFICATION OF MEDICARE INELIGIBILITY STATUS**

Other Medical Coverage (Please check YES or NO):

1) Does another employer or any other retirement medical plan currently cover you or your spouse or other dependent? (e.g. CHAMPUS, TRI-CARE) YES
 NO

If **YES**, please provide the following information:
 NAME OF INSURED: _____ INSURANCE NAME: _____
 POLICY NUMBER: _____

2) Does you, your spouse or other dependent(s) currently receive Medicare premium reimbursement from another employer? YES
 NO
Please note: You (or your dependents) cannot claim dual Medicare reimbursement from the District. If your answer is "YES", do not provide proof for Medicare reimbursement for these individuals.

If **YES**, please list the source(s) and certify below. (If **NO**, skip to next section):

NAME OF MEDICARE REIMBURSEMENT RECIPIENT(S):

SOCIAL SECURITY NUMBERS(S): _____ SOURCE(S): _____

I do not wish to receive Medicare reimbursement from the Foothill-De Anza Community College District because I am currently receiving the same reimbursement from another employer:

RETIREE'S SIGNATURE: _____ DATE: _____

SPOUSE/DP'S SIGNATURE: _____ DATE: _____

I hereby certify that I am in compliance with the contractual requirements for eligibility for retiree benefits and that the information I have provided is correct.

RETIREE'S SIGNATURE: _____ DATE: _____

SPOUSE'S/DP'S SIGNATURE: _____ DATE: _____

SUBMIT THIS FORM TO HUMAN RESOURCES *ALONG WITH* THE (1) RETIREE DATA UPDATE, (2) PROOF(S) OF MEDICARE PAYMENT, (3) COPY OF MEDICARE I.D. CARD(S)—*if applicable—new Medicare-eligible members only*, and (4) SSA CERTIFICATION OF MEDICARE INELIGIBILITY STATUS—*if applicable* BY DEADLINE: THURSDAY, MARCH 15, 2012.

To receive Quarterly Medicare reimbursement for the First Quarter 2012 (January –March), or **April 15, 2012**, your proofs of Medicare Part B payment must be received by March 15, 2012. Late notices received by the District between March 16-31, 2012 will be processed along with the second quarter refund (April-June) or July 15, 2012. The above rule is enforced for current qualified Medicare recipients only. Newly qualified members effective date of reimbursement is based on their dates of qualification, and date of notice received. For example, if you are newly eligible for Medicare effective March 1, 2012, and we received your documentation on April 20, 2012, then you have missed the one-month of premium reimbursement, the effective date of Medicare reimbursement in this case is April 1, 2012. Hence, it is important that you meet the deadline to avoid any delay in payment.

PLEASE FAX OR MAIL: (1) THE SURVEY, PROOF(S) OF MEDICARE PAYMENT, (2) COPY OF MEDICARE I.D. CARD(S) – **THIS CARD IS REQUIRED FOR ALL NEW MEDICARE ELIGIBLE MEMBERS ONLY, AND/OR (3) SSA CERTIFICATION OF MEDICARE INELIGIBILITY STATUS TO:**

FOOTHILL-DE ANZA COMMUNITY COLLEGE DISTRICT

ATTN: BENEFITS UNIT

12345 EL MONTE RD

LOS ALTOS HILLS, CA 94022

FAX: (650) 949-2831 EMAIL: MyBenefits@fhda.edu

NOTE: If you wish to receive a confirmation notice regarding your mailing to us, please send your mail via certified mail, or request confirmation via email to: MyBenefits@fhda.edu, **please allow 48-72 hours for a reply**). Unfortunately, due to limited resources, we cannot confirm by phone. Thank you.