FOOTHILL-DE ANZA RETIREE BENEFIT PLAN
FOR EMPLOYEES HIRED ON OR AFTER JULY 1, 1997
VEBA FHDA

VEBA FHDA Benefit Application Enrollment Form

1. GENERAL INFORMATION:

This program provides a limited Medicare Part B Premium Reimbursement benefit to eligible former employees of Foothill-De Anza Community College.

You will need to fill out this VEBA FHDA Benefit Application Enrollment Form once when you first enroll. Annually thereafter, you must submit your Proof of Medicare Part B Insurance Premium by January 31st as outlined below in order to continue eligibility for this benefit. The Plan will issue reimbursements on a quarterly basis.

Instructions:

- **Please read and complete this Application in full and sign and date where indicated.**
- **Please provide a copy of your valid Driver's License or other government issued photo ID.**
- **Please provide proof of your monthly Medicare Part B Insurance Premium as outlined below.**
- **Return the completed Application along with all required documents when you first enroll in Medicare, to the Trust Fund Office located at: United Administrative Services, 6800 Santa Teresa Blvd., Suite 100, San Jose, CA 95119.**

2. ENROLLMENT INFORMATION:

Please Fill in the Following Information:

Name:	
Address:	
E-mail Address:	
Home Phone No.:	
Cell Phone No.:	
Social Security No.:	
Date of Birth: (attach a copy of your license or other photo ID)	
Date you last worked or will work as a full-time employee:	

3. PROOF OF MEDICARE INSURANCE PREMIUM

You must submit proof of the amount of your monthly Medicare Part B Insurance Premium to the Trust Fund Office at the address stated below when you first enroll in Medicare, and annually thereafter.

You must provide one of the following as proof along with this completed VEBA FHDA Benefit Application Enrollment Form to initiate the Part B reimbursement benefit; you must also submit this documentation annually in order to continue eligibility to receive this benefit:

1. A copy of your Notice of Medicare Part B Premium Payment Due (CMS 500); **or**
2. Your annual Social Security Benefit Rate Change Notice from Social Security with the amount of your Medicare Part B premium deduction for the coming year; **or**
3. Evidence that the Part B premium has been deducted from your social security payment; **or**
4. Other evidence acceptable to the Board of Trustees of the Plan.

If you are not receiving Social Security benefits yet, then you must provide one of the following as proof along with this completed VEBA FHDA Benefit Application Enrollment Form:

1. Evidence you paid the Medicare Part B Insurance Premium; **or**
2. Other documentation acceptable to the Board of Trustees.

4. ELIGIBILITY

Please Read Carefully And Certify You Are Eligible To Receive Benefits:

I hereby certify that I am eligible to receive benefits under the Plan and the following Plan requirements have been met:

1. I am a former employee of the District and was hired on or after July 1, 1997, and during my period(s) of employment I rendered service to the District at least half-time as a contract or regular employee in a position for which I was eligible to enroll in District active health coverage for 15 years or more of continuous service prior to my retirement;

2. I separated from employment as a contract or regular employee in any position for which I was eligible to enroll in District active health coverage, regardless of whether I have yet retired as a service retirement or disability retirement annuitant of the State Teachers Retirement System or the Public Employees Retirement System; and

3. I have provided evidence that I am eligible for Medicare coverage, have enrolled in and begun/will begin receiving Medicare Part B coverage, have paid/will be paying a premium for Medicare Part B coverage, and am not/will not be receiving reimbursement for that Medicare Part B premium from any other source.

_____	_____
Signature	Date

5. PAYMENT FORM OPTIONS

Payments will be issued by paper checks to the address you provided above, unless you elect to receive payment by direct deposit. If you choose to be reimbursed by direct deposit, you must fill out the additional Direct Deposit Enrollment form, enclosed.

Please check the box next to how you would like to receive your payment:

[ ] I would like to receive quarterly payments by paper check sent to the address listed above.

[ ] I would like to receive quarterly payments by direct deposit and I have completed and attached the additional Direct Deposit Enrollment form.

6. SIGNATURE AND DATE:

Please read carefully and attest to the following:

1. I have certified that I am eligible to participate in the Plan and have provided all requested forms and documentation as required under the Plan.

2. All the information contained in the this VEBA FHDA Benefit Application Enrollment Form is true and correct to the best of my knowledge, and I understand that providing false or misleading information in my Application may result in immediate denial of my Application or the provision of receiving benefits.

3. I acknowledge that I must continue to provide proof of my Medicare Insurance Part B Premium, as outlined above, by January 31st of each year and understand that failure to provide such proof annually may result in my failure to receive benefits.

4. I understand that the monthly reimbursement amount is not a guaranteed benefit and subject to change at any time by the Board of Trustees of the Plan depending on the funds available in the VEBA FHDA Plan and the number of current and projected reimbursement claim requests.

I hereby acknowledge that I have provided all requested information and wish to apply for reimbursement of my monthly Medicare Part B Insurance Premium at this time.

_____ _____

Signature Date

7. HOW TO SUBMIT:

Please submit all completed documentation to the Trust Fund Office at the following address:

United Administrative Services
6800 Santa Teresa Blvd., Suite 100
San Jose, CA 95119
(408)–288–4400

Documents to Submit:

Please make sure you have submitted the following documents:

1. Completed Benefits Application Enrollment Form.
2. Copy of Driver's License or other state issued photo ID.
3. All required Proof of Medicare Part B Insurance Premium.
4. Completed Direct Deposit Enrollment Form (only if you wish to receive payment by direct deposit)

Deadlines for Submitting:

- This VEBA FHDA Benefit Application Enrollment Form is required when you first enroll in Medicare.
- Thereafter, you must continue to provide proof of the amount of your monthly Medicare Part B Insurance Premium to the Trust Fund Office by January 31st of each year. Your submission is considered late if received by the Trust Fund Office after February 15th. (For example, if your proof of the amount of your Medicare Part B Insurance Premium is received on February 16th, then you will not be reimbursed for your premium payments incurred for January, February and March).

8. QUESTIONS REGARDING APPLICATION / HOW TO CHANGE INFORMATION

If you have any questions regarding the application and enrollment process, please contact the Trust Fund Office at the address or phone number stated above.

If you need to change any of your information in the future, please contact the Trust Fund Office and inform them of any necessary changes.