LOS ANGELES COMMUNITY COLLEGE DISTRICT

Application for Continuation of Health Benefits for Survivors

I wish to apply for the continuation of health benefits as the spouse and/or eligible dependent(s) of a deceased employee or retiree. I have previously been covered as the spouse or dependent of the employee or retiree indicated below.

(Complete the form below if you are a survivor of a LACCD employee/retiree)		
EMPLOYEE/RETIREE INFORMATION		
1. Name (Last, First, MI)		
2. Employee Number		
3. Social Security Number		
4. Date of Death		
APPLICANT INFORMATION		
5. Name		
6. Address		
7. City, State, Zip		
8. Telephone Number (Including Area Code)		
9. Social Security Number	**10. Date of Birth**	**11. Male ☐ Female ☐**
12. Relationship to Employee/Retiree		
13. Name, Address and Telephone Number of Present Employer or Organization from which You Retired, if Applicable		
14. Do you receive or are you eligible for hospital/medical, dental, and/or vision coverage (excluding Medicare) from the employer or organization listed in item 13? Yes ☐ No ☐		
15. If yes, list the name of the company furnishing benefits (e.g. Kaiser, Blue Cross, etc.):		
Hospital/Medical:	**Group Number:**	
Dental:	**Group Number:**	
Vision:	**Group Number:**	
16. Are you currently enrolled and receiving Medicare coverage? Yes ☐ No ☐		
17. If yes to item 16 above, please indicate the following:		
Medicare Claim Number:		
Part A Effective Date:		
Part B Effective Date:		
18. Provide the name of someone outside your household who will always know how to contact you.		
Name		
Relationship	**Telephone ( )**	
DEPENDENT INFORMATION **(Please list eligible dependent/s who are currently covered under the retiree's plan.)**		
19. Name (Last, First, MI)		
20. Relationship to employee/retiree		
21. Social Security Number	**22. Date of Birth**	**23. Male ☐ Female ☐**
24. Name (Last, First, MI)		
25. Relationship to employee/retiree		
26. Social Security Number	**27. Date of Birth**	**28. Male ☐ Female ☐**
29. Name (Last, First, MI)		
30. Relationship to employee/retiree		

31. Social Security Number	32. Date of Birth	33. Male ☐ Female ☐

34. Please enroll me and/or my eligible dependents in the following plans. (You and/or your eligible dependents are only eligible to enroll in the plans which you are currently enrolled as a dependent.)

This medical election is for:

☐ **Me**
☐ **Me and my eligible dependents**

☐ **Blue Shield PPO**
☐ **Blue Shield HMO**

☐ **Kaiser Permanente**

This dental election is for:

☐ **Me**
☐ **Me and my eligible dependents**

☐ **Delta Dental**

☐ **Safeguard**

This vision election is for:

☐ **Me**

☐ **Me and my eligible dependents**

I understand that the elections I make on this form will remain in effect as long as I am eligible or until I make another election during Open Enrollment. I hereby authorize any insurance company, organization, employer, physician, surgeon, pharmacist or other health care provider to release any information requested to pay any claim under the plan(s) I have elected. I am enrolling myself (or refusing coverage) and those eligible dependents I have listed on the Application for Continuation of Health Benefits for Survivors Form for coverage under the plan(s) I have elected. I understand that I am responsible for reporting any change(s) in the eligibility status of my dependents. I also understand that the benefits and services of the plan(s) I elected are coordinated with those provided by any other group hospital, medical or dental benefit or service plan. I understand that I must abide by the provisions of the plan(s) I have elected and that any controversy or discrepancy between any plan member and such plan(s) (including its agents, staff physicians, employees and providers) is subject to binding arbitration. By signing this form below, I certify that I understand the benefits options available to me and accept full responsibility for my elections. I also certify that the information and documentation I have provided are true and accurate to the best of my knowledge.

Your Signature_____ **Date**_____

Note: Please initial that you have received copy of Board Rule (101700, Health Benefit Group coverage for -survivors) enclosed on the line provided. _____