Early Retirement Benefits

Medical, Dental, Vision,
Life Insurance

Who Qualifies?

Early Retirement

- Between 55 and 65 years old
- Worked for the District for at least 10 years

Disability Retirement

- Between 50 and 65 years old
- Worked for the District for at least 15 years

Your Benefits Packet

Each packet is custom made for you based on:

- Your age
- Certificated or Classified
- Number of years employed with GGUSD
- Current health plans
- Spouse and/or dependents

Your Benefits Packet

Packet contains:

- Cover letter

1) Benefits for Retiring or Resigning Employees
   Certificated – Blue Classified – Green
2) GGUSD Enroll/Change Form
   and HMO Enroll Forms (as applicable)
3) Ins. Election and Authorization - Retiree
4) AB528 Dental Rates (Certificated Only)
5) COBRA Cont. Coverage Rates
6) Retiree Medicare Info

1) Benefits for Early Retirees

MEDICAL

- Early retiree plan is a continuation of your active medical benefits. **(Must submit enrollment form.)**
- Qualified retiree is eligible for coverage for self and spouse **until employee turns age 65.**
- District will pay part of premium for retiree and spouse only, not dependent children.

1) Benefits for Early Retirees

MEDICAL

- Cost to Continue Medical:

Retiree	• $450 / year
Retiree & Spouse	• $900 / year

- Billed semi-annually (Jan/July)
- Must submit enrollment forms to Ins. Dept. **within 31 days of loss of active coverage.**

1) Benefits for Early Retirees

DENTAL

- Your District paid Dental plan terms at the end of the month in which you retire.

- To Continue Dental:

Certificated

- Enroll in COBRA for **up to 18 months** (billed monthly)

OR

- Enroll in AB528 **indefinitely** (billed quarterly)

Classified

- Enroll in COBRA for **up to 18 months** (billed monthly)

1) Benefits for Early Retirees

DENTAL

Certificated

- AB528 Dental Rate Sheet included in packet (#4)
- Must enroll <u>within 31 days of loss of active coverage.</u>
- Cannot add it later
- If coverage terminates at any time, cannot re-enroll at later date.

1) Benefits for Early Retirees

VISION

- Your District paid Vision plan terminates at the end of the month in which you retire.

- To Continue Vision:

Certificated and Classified

- Enroll in COBRA for **up to 18 months** (billed monthly)

1) Benefits for Early Retirees

LIFE

- Your District paid Life Ins. plan terminates at the end of the month in which you retire.

- To Continue Life:

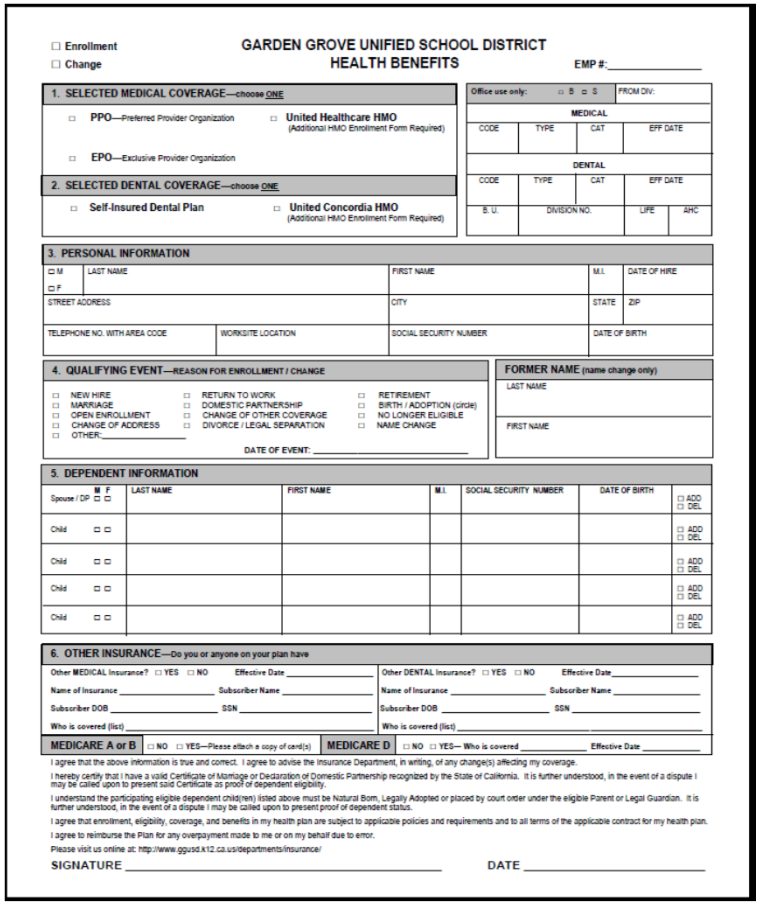
Certificated and Classified

- Option to convert to individual policy from MetLife
- Conversion plan may be costly
- Contact GGUSD Ins. Office

2) GGUSD/HMO Enrollment Forms

Included in packet (as applicable):

- **GGUSD Health Benefits Enroll/Change Form (PPO, EPO & HMO)**
  - Anthem Blue Cross HMO Enroll Form
  - United Concordia Dental HMO Enroll Form



☐ Enrollment
☐ Change

GARDEN GROVE UNIFIED SCHOOL DISTRICT
HEALTH BENEFITS

EMP #:_____

1. SELECTED MEDICAL COVERAGE—choose ONE

☐ PPO—Preferred Provider Organization ☐ United Healthcare HMO (Additional HMO Enrollment Form Required)

☐ EPO—Exclusive Provider Organization

2. SELECTED DENTAL COVERAGE—choose ONE

☐ Self-Insured Dental Plan ☐ United Concordia HMO (Additional HMO Enrollment Form Required)

Office use only: ☐ S ☐ S FROM DIV:

MEDICAL: CODE | TYPE | CAT | EFF DATE

DENTAL: CODE | TYPE | CAT | EFF DATE

B. U. | DIVISION NO. | LIFE | AHC

3. PERSONAL INFORMATION

☐ M ☐ F | LAST NAME | FIRST NAME | M.I. | DATE OF HIRE

STREET ADDRESS | CITY | STATE | ZIP

TELEPHONE NO. WITH AREA CODE | WORKSITE LOCATION | SOCIAL SECURITY NUMBER | DATE OF BIRTH

4. QUALIFYING EVENT—REASON FOR ENROLLMENT / CHANGE

☐ NEW HIRE ☐ MARRIAGE ☐ OPEN ENROLLMENT ☐ CHANGE OF ADDRESS ☐ OTHER:_____
☐ RETURN TO WORK ☐ DOMESTIC PARTNERSHIP ☐ CHANGE OF OTHER COVERAGE ☐ DIVORCE / LEGAL SEPARATION
☐ RETIREMENT ☐ BIRTH / ADOPTION (circle) ☐ NO LONGER ELIGIBLE ☐ NAME CHANGE

DATE OF EVENT: _____

FORMER NAME (name change only)
LAST NAME
FIRST NAME

5. DEPENDENT INFORMATION

Spouse / DP ☐ M ☐ F	LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER	DATE OF BIRTH	☐ ADD ☐ DEL
Child ☐ ☐						☐ ADD ☐ DEL
Child ☐ ☐						☐ ADD ☐ DEL
Child ☐ ☐						☐ ADD ☐ DEL
Child ☐ ☐						☐ ADD ☐ DEL

6. OTHER INSURANCE—Do you or anyone on your plan have

Other MEDICAL Insurance? ☐ YES ☐ NO Effective Date _____
Name of Insurance _____ Subscriber Name _____
Subscriber DOB _____ SSN _____
Who is covered (list) _____

Other DENTAL Insurance? ☐ YES ☐ NO Effective Date _____
Name of Insurance _____ Subscriber Name _____
Subscriber DOB _____ SSN _____
Who is covered (list) _____

MEDICARE A or B ☐ NO ☐ YES—Please attach a copy of card(s) **MEDICARE D** ☐ NO ☐ YES— Who is covered _____ Effective Date _____

I agree that the above information is true and correct. I agree to advise the Insurance Department, in writing, of any change(s) affecting my coverage.

I hereby certify that I have a valid Certificate of Marriage or Declaration of Domestic Partnership recognized by the State of California. It is further understood, in the event of a dispute I may be called upon to present said Certificate as proof of dependent eligibility.

I understand the participating eligible dependent child(ren) listed above must be Natural Born, Legally Adopted or placed by court order under the eligible Parent or Legal Guardian. It is further understood, in the event of a dispute I may be called upon to present proof of dependent status.

I agree that enrollment, eligibility, coverage, and benefits in my health plan are subject to applicable policies and requirements and to all terms of the applicable contract for my health plan.

I agree to reimburse the Plan for any overpayment made to me or on my behalf due to error.

Please visit us online at: http://www.ggusd.k12.ca.us/departments/insurance/

SIGNATURE _____ DATE _____

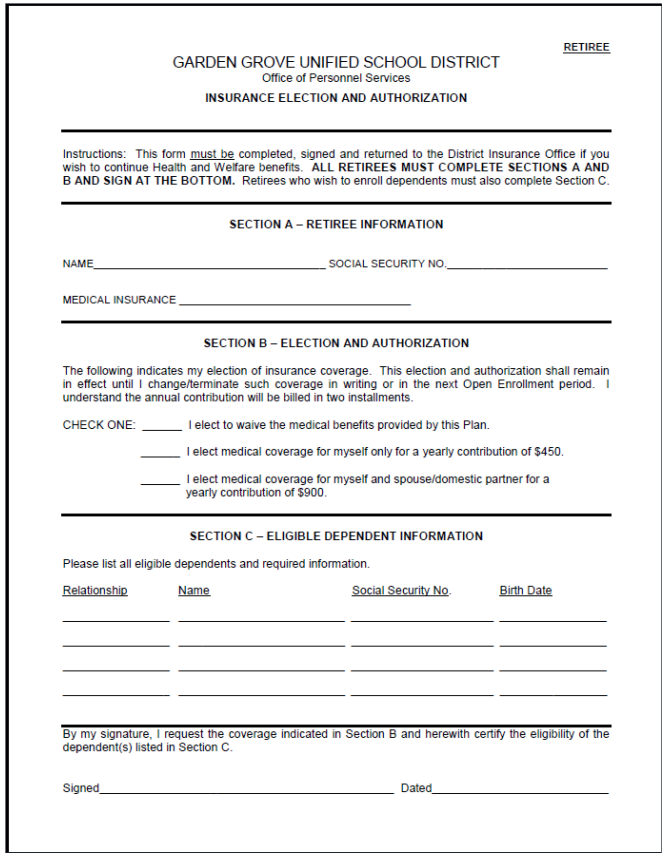
3) Insurance Election & Authorization - Retiree

Section A **Retiree Information**

Section B

- **Election of coverage OR to waive benefits**
- **Medical coverage for self only – Annual Rate: $450**
- **Medical coverage for self and spouse/domestic partner – Annual Rate: $900**

- **Billed semi-annually**



RETIREE

GARDEN GROVE UNIFIED SCHOOL DISTRICT
Office of Personnel Services
INSURANCE ELECTION AND AUTHORIZATION

Instructions: This form must be completed, signed and returned to the District Insurance Office if you wish to continue Health and Welfare benefits. **ALL RETIREES MUST COMPLETE SECTIONS A AND B AND SIGN AT THE BOTTOM.** Retirees who wish to enroll dependents must also complete Section C.

SECTION A – RETIREE INFORMATION

NAME_____ SOCIAL SECURITY NO._____

MEDICAL INSURANCE _____

SECTION B – ELECTION AND AUTHORIZATION

The following indicates my election of insurance coverage. This election and authorization shall remain in effect until I change/terminate such coverage in writing or in the next Open Enrollment period. I understand the annual contribution will be billed in two installments.

CHECK ONE: _____ I elect to waive the medical benefits provided by this Plan.

_____ I elect medical coverage for myself only for a yearly contribution of $450.

_____ I elect medical coverage for myself and spouse/domestic partner for a yearly contribution of $900.

SECTION C – ELIGIBLE DEPENDENT INFORMATION

Please list all eligible dependents and required information.

Relationship	Name	Social Security No.	Birth Date

By my signature, I request the coverage indicated in Section B and herewith certify the eligibility of the dependent(s) listed in Section C.

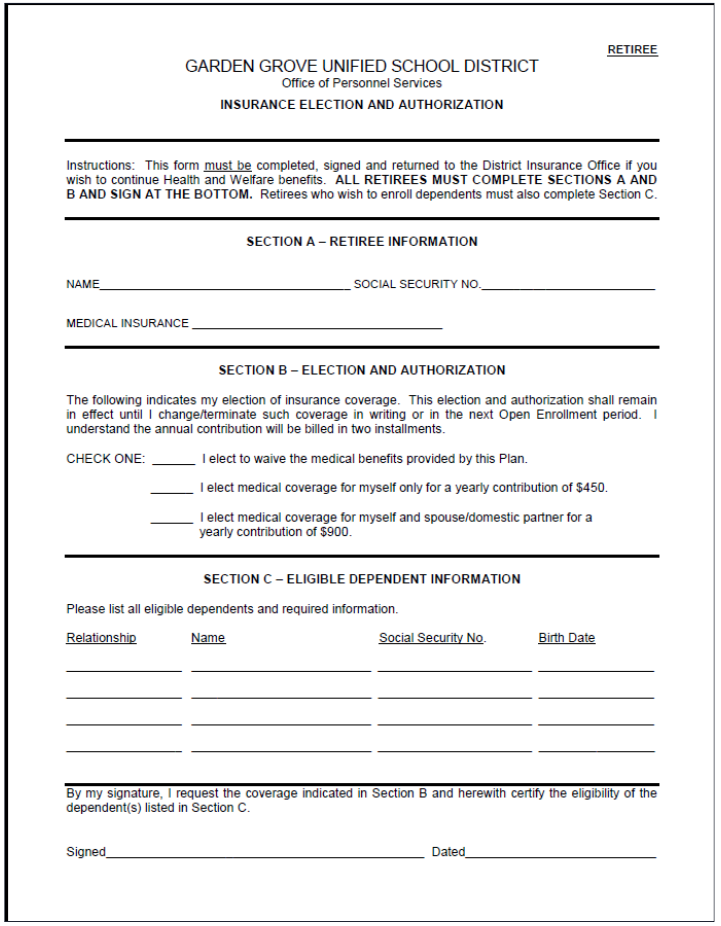
Signed_____ Dated_____

3) Insurance Election & Authorization - Retiree

Section C

- **Eligible Dependent Info.**
- **You can purchase coverage for eligible dependent children but monthly rate is quite high.**
  - **provided as applicable**
  - **billed quarterly**
- **<u>Signature Line</u>**

Be sure to sign and date form



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SECTION A – RETIREE INFORMATION

NAME_____ SOCIAL SECURITY NO._____

MEDICAL INSURANCE _____

SECTION B – ELECTION AND AUTHORIZATION

The following indicates my election of insurance coverage. This election and authorization shall remain in effect until I change/terminate such coverage in writing or in the next Open Enrollment period. I understand the annual contribution will be billed in two installments.

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Signed_____ Dated_____

4) Retiree AB528 Dental Coverage

Certificated

- **Rate sheet provides <u>quarterly</u> rates as applicable:**
  - **Self-Insured Dental OR**
  - **United Concordia Dental HMO**

- **Return enroll forms with payment *(up to next quarterly due date)***

- **You must continue with current plan, but may change plans during Open Enrollment *(October)***

5) COBRA Rates

Dental and Vision

- **Effective Date: 1st of month after retirement date**
- **Coverage offered for 18 months**
  You may cancel at any time
- **Applicable monthly rates**
- **Deadline to enroll: 60 days from latter of loss of active coverage or Cobra notice date**

5) COBRA Rates

- **Notice mailed to you from PayPro Administrators**
- **To apply, return COBRA Cont. Coverage Election Form by stated deadline as instructed in notice.**
- **You must continue with current plan, but may change plans during Open Enrollment.**
- **Also need United Concordia Dental HMO Form if applicable.**
- **Notice contains important info. you should read.**
- **Once COBRA ends, the District does not offer any other options for dental or vision.**

6) Medicare

- **As an Active Employee, GGUSD's medical is PRIMARY and Medicare is SECONDARY for both you and your spouse, regardless of Medicare eligibility.**
- **As an Early Retiree or Dependent Spouse of an Early Retiree, GGUSD medical is PRIMARY until you are eligible for Medicare (regardless of enrollment), and GGUSD will be SECONDARY.**

6) Medicare

- **Contact Medicare 3 months prior to age 65.**
- **Early Retiree or Spouse, turning 65:**

  - extremely important to ENROLL in Medicare Parts A and B as soon as you are eligible

  - may elect not to take Part D to continue use of GGUSD's RX plan as PRIMARY

- **Resource – Medicare Counselors**

  - HICAP phone # 714-560-0424

Summary

- **Early Retiree MEDICAL billed semi-annually**
  - 31 days from loss of active coverage to enroll
  - No payment required with application
- **COBRA DENTAL & VISION billed monthly**
  - 60 days from latter of: loss of active coverage or Cobra notice date to enroll
  - App./Pmt. to PayPro Administrators

Summary

- **AB528 DENTAL billed quarterly (Certificated)**
  - **31 days from loss of active coverage to enroll**
  - **Remit payment to GGUSD with application**
- **Important to keep us updated on any address or other coverage changes**

Contact Information

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