Early Retirement Benefits

Who Qualifies?

Early Retirement Medical Plan

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

Disability Retirement Medical Plan

- 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:

- Certificated or Classified
- Current health plans
- Spouse and/or dependents

Your Benefits Packet

Packet contains:

- Cover letter

1) Benefits for Retiring or Resigning Employees
2) GGUSD Enrollment / Change Form
   and HMO Enroll Forms (as applicable)
3) Insurance Election and Authorization - Retiree
4) AB528 Dental Rates (Certificated Only)
5) COBRA Continuation of 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 pays majority 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. 1 / July 1)
- 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	Classified
• Enroll in COBRA for **up to 18 months** (billed monthly) OR • Enroll in AB528 **indefinitely** (billed quarterly)	• 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 within 31 days of loss of active coverage.
- If coverage terminates at any time due to non-pay, cannot re-enroll later.

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 mos.** (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:

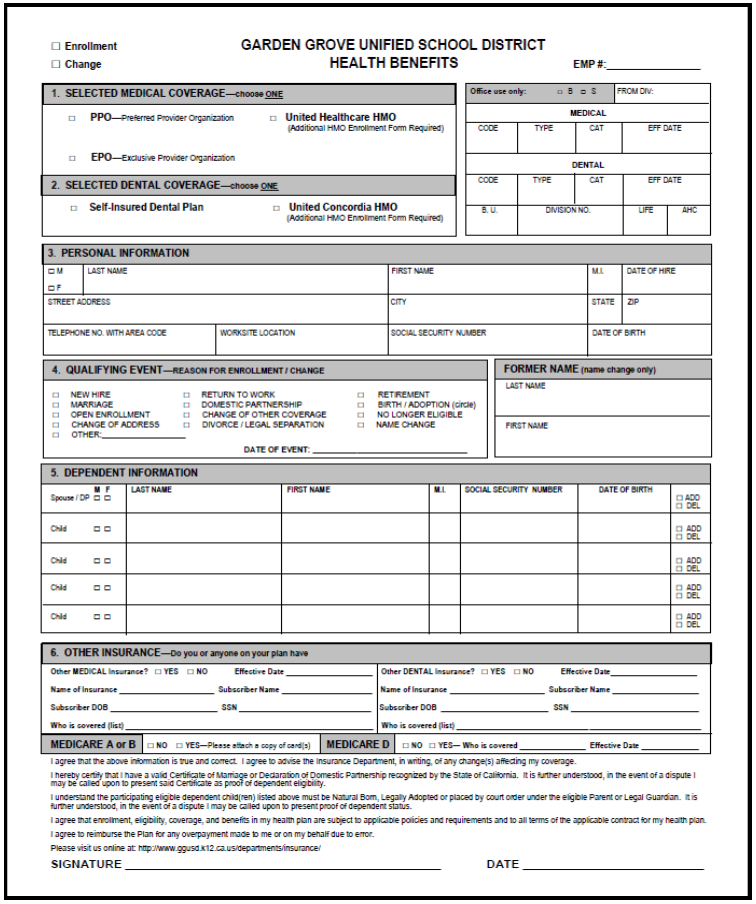
Certificated and Classified

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

DATE OF EVENT: _____

FORMER NAME (name change only)

LAST NAME

FIRST NAME

5. DEPENDENT INFORMATION

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

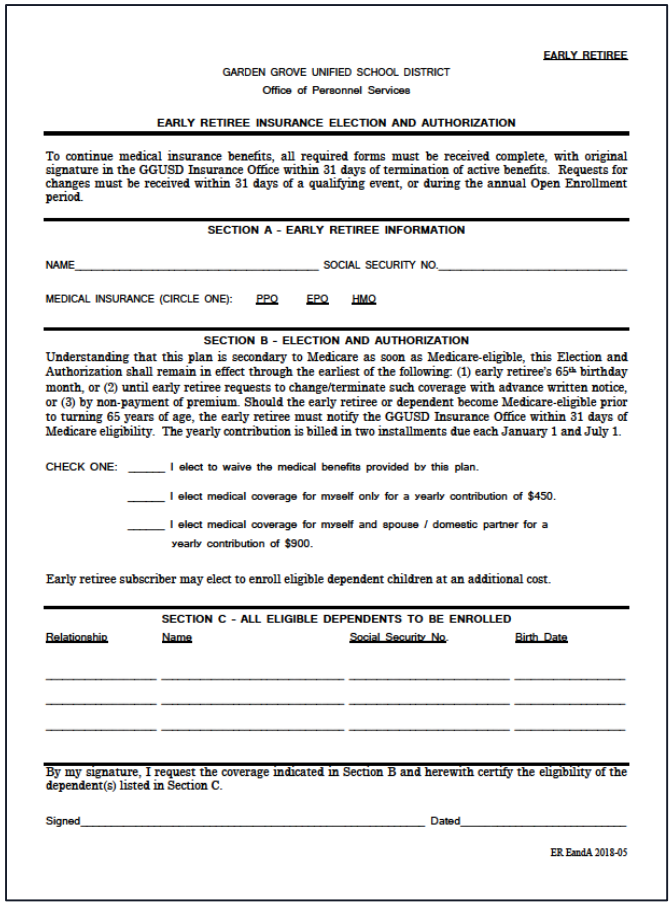
3) Insurance Election & Authorization - Retiree

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**



EARLY RETIREE

GARDEN GROVE UNIFIED SCHOOL DISTRICT
Office of Personnel Services

EARLY RETIREE INSURANCE ELECTION AND AUTHORIZATION

To continue medical insurance benefits, all required forms must be received complete, with original signature in the GGUSD Insurance Office within 31 days of termination of active benefits. Requests for changes must be received within 31 days of a qualifying event, or during the annual Open Enrollment period.

SECTION A - EARLY RETIREE INFORMATION

NAME_____ SOCIAL SECURITY NO._____

MEDICAL INSURANCE (CIRCLE ONE): PPO EPO HMO

SECTION B - ELECTION AND AUTHORIZATION

Understanding that this plan is secondary to Medicare as soon as Medicare-eligible, this Election and Authorization shall remain in effect through the earliest of the following: (1) early retiree's 65th birthday month, or (2) until early retiree requests to change/terminate such coverage with advance written notice, or (3) by non-payment of premium. Should the early retiree or dependent become Medicare-eligible prior to turning 65 years of age, the early retiree must notify the GGUSD Insurance Office within 31 days of Medicare eligibility. The yearly contribution is billed in two installments due each January 1 and July 1.

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.

Early retiree subscriber may elect to enroll eligible dependent children at an additional cost.

SECTION C - ALL ELIGIBLE DEPENDENTS TO BE ENROLLED

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_____

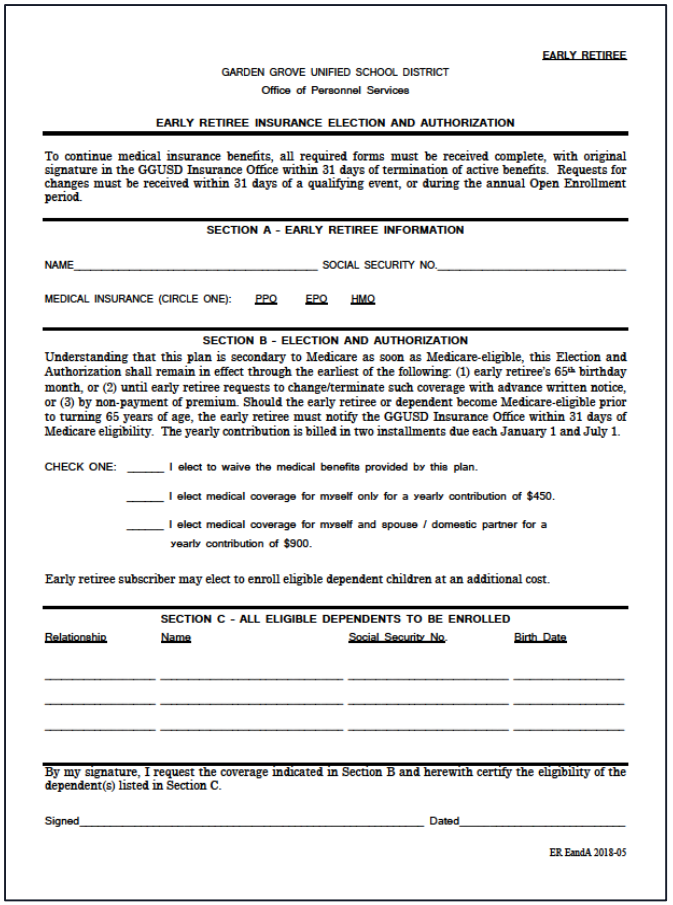
ER EandA 2018-05

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



EARLY RETIREE

GARDEN GROVE UNIFIED SCHOOL DISTRICT
Office of Personnel Services

EARLY RETIREE INSURANCE ELECTION AND AUTHORIZATION

To continue medical insurance benefits, all required forms must be received complete, with original signature in the GGUSD Insurance Office within 31 days of termination of active benefits. Requests for changes must be received within 31 days of a qualifying event, or during the annual Open Enrollment period.

SECTION A - EARLY RETIREE INFORMATION

NAME_____ SOCIAL SECURITY NO._____

MEDICAL INSURANCE (CIRCLE ONE): PPO EPO HMO

SECTION B - ELECTION AND AUTHORIZATION

Understanding that this plan is secondary to Medicare as soon as Medicare-eligible, this Election and Authorization shall remain in effect through the earliest of the following: (1) early retiree's 65th birthday month, or (2) until early retiree requests to change/terminate such coverage with advance written notice, or (3) by non-payment of premium. Should the early retiree or dependent become Medicare-eligible prior to turning 65 years of age, the early retiree must notify the GGUSD Insurance Office within 31 days of Medicare eligibility. The yearly contribution is billed in two installments due each January 1 and July 1.

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.

Early retiree subscriber may elect to enroll eligible dependent children at an additional cost.

SECTION C - ALL ELIGIBLE DEPENDENTS TO BE ENROLLED

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_____

ER EandA 2018-05

4) Retiree AB528 Dental Coverage

Certificated

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

- **Return enrollment forms with quarterly pmt.**

- **Must continue with current plan; 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 date of Cobra notice.**

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.**

IMPORTANT

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, once Medicare-eligible, GGUSD will be SECONDARY (regardless of enrollment).**

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 Only)**
  - **31 days from loss of active coverage to enroll**
  - **Remit payment to GGUSD with app.**
  - **Important to keep us updated on any address or other coverage changes (Provide copy of Medicare card w/in 31 days of enrollment.)**

Contact Information

(714) 663-6523

Kimberly I. Bessey
kbessey@ggusd.us

Evette Chiang
echiang@ggusd.us

Jan Hill
jhill1@ggusd.us

1. SELECTED MEDICAL COVERAGE—choose ONE

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

☐ EPO—Exclusive Provider Organization

Plan Change From _____ To _____

Mark which plan you are currently enrolled in.

Office use only: ☐ EIA ☐ HR ☐ S FROM DIV:

EFF DATE

2. SELECTED DENTAL COVERAGE—choose ONE

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

Plan Change From _____ To _____

Certificated AB528 Only

DENTAL

EFF DATE

LIFE AHC

3. PERSONAL INFORMATION

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

STREET ADDRESS | STATE | ZIP

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

Enter your current address, ID numbers, etc. If you are moving soon, give us new address and effective date.

4. QUALIFYING EVENT—REASON FOR ENROLLMENT / CHANGE

☐ NEW HIRE ☐ RETURN TO WORK ☐ RETIREMENT

☐ MARRIAGE ☐ ☐ BIRTH / ADOPTION (circle)

☐ OPEN ENROLLMENT ☐ ☐ NAME CHANGE

☐ CHANGE OF ADDRESS ☐ ☐ OTHER: _____

DATE OF EVENT: _____

Check event that applies and date of event

FORMER NAME (name change only)

LAST NAME

FIRST NAME

5. DEPENDENT INFORMATION

	M F	LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER	DATE OF BIRTH	
Spouse / DP	☐ ☐						☐ NO CHG ☐ ADD ☐ DEL
Child	☐ ☐						☐ NO CHG ☐ ADD ☐ DEL
Child	☐ ☐						☐ NO CHG ☐ ADD ☐ DEL
Child	☐ ☐						☐ NO CHG ☐ ADD ☐ DEL
Child	☐ ☐						☐ NO CHG ☐ ADD ☐ DEL

Enter spouse information here. Can add other dependents currently enrolled but very expensive.

6. OTHER INSURANCE COVERAGE—DO YOU OR ANYONE ON YOUR PLAN HAVE:

Other MEDICAL Insurance? ☐ YES ☐ NO

Start Date _____ End Date _____

Name of Insurance _____

Subscriber Name _____

Subscriber ID# _____ DOB _____

Who is covered (list) _____

Other DENTAL Insurance? ☐ YES ☐ NO

Start Date _____ End Date _____

DOB _____

Mark YES and answer all questions if you or anyone on your plan have other medical or dental coverage. This includes double coverage with district employees and/or Medicare.

MEDICARE A or B ☐ NO ☐ YES—Please attach a copy of ce... 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.