



# 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 within 31 days of loss of active coverage.

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

GARDEN GROVE UNIFIED SCHOOL DISTRICT HEALTH BENEFITS																																																									
<input type="checkbox"/> Enrollment <input type="checkbox"/> Change					EMP #: _____																																																				
<b>1. SELECTED MEDICAL COVERAGE—choose ONE</b> <input type="checkbox"/> PPO—Preferred Provider Organization <input type="checkbox"/> United Healthcare HMO <small>(Additional HMO Enrollment Form Required)</small> <input type="checkbox"/> EPO—Exclusive Provider Organization					<b>Office use only:</b> <input type="checkbox"/> B <input type="checkbox"/> S    FROM DIV: _____ <table border="1"> <tr> <th colspan="4">MEDICAL</th> </tr> <tr> <td>CODE</td> <td>TYPE</td> <td>CAT</td> <td>EFF DATE</td> </tr> <tr> <td colspan="4"> </td> </tr> <tr> <th colspan="4">DENTAL</th> </tr> <tr> <td>CODE</td> <td>TYPE</td> <td>CAT</td> <td>EFF DATE</td> </tr> <tr> <td colspan="4"> </td> </tr> <tr> <td>S. U.</td> <td>DIVISION NO.</td> <td>LIFE</td> <td>ARC</td> </tr> </table>					MEDICAL				CODE	TYPE	CAT	EFF DATE					DENTAL				CODE	TYPE	CAT	EFF DATE					S. U.	DIVISION NO.	LIFE	ARC																				
MEDICAL																																																									
CODE	TYPE	CAT	EFF DATE																																																						
DENTAL																																																									
CODE	TYPE	CAT	EFF DATE																																																						
S. U.	DIVISION NO.	LIFE	ARC																																																						
<b>2. SELECTED DENTAL COVERAGE—choose ONE</b> <input type="checkbox"/> Self-Insured Dental Plan <input type="checkbox"/> United Concordia HMO <small>(Additional HMO Enrollment Form Required)</small>																																																									
<b>3. PERSONAL INFORMATION</b> <input type="checkbox"/> M    LAST NAME _____    FIRST NAME _____    M.I. _____    DATE OF HIRE _____ <input type="checkbox"/> F    STREET ADDRESS _____    CITY _____    STATE _____    ZIP _____ TELEPHONE NO. WITH AREA CODE _____    WORKSITE LOCATION _____    SOCIAL SECURITY NUMBER _____    DATE OF BIRTH _____																																																									
<b>4. QUALIFYING EVENT—REASON FOR ENROLLMENT / CHANGE</b> <input type="checkbox"/> NEW HIRE <input type="checkbox"/> RETURN TO WORK <input type="checkbox"/> RETIREMENT <input type="checkbox"/> MARRIAGE <input type="checkbox"/> DOMESTIC PARTNERSHIP <input type="checkbox"/> BIRTH / ADOPTION (if new) <input type="checkbox"/> OPEN ENROLLMENT <input type="checkbox"/> CHANGE OF OTHER COVERAGE <input type="checkbox"/> NO LONGER ELIGIBLE <input type="checkbox"/> CHANGE OF ADDRESS <input type="checkbox"/> DIVORCE / LEGAL SEPARATION <input type="checkbox"/> NAME CHANGE <input type="checkbox"/> OTHER: _____    DATE OF EVENT: _____								<b>FORMER NAME (name change only)</b> LAST NAME _____ FIRST NAME _____																																																	
<b>5. DEPENDENT INFORMATION</b> <table border="1"> <thead> <tr> <th>Spouse / DP</th> <th>M / F</th> <th>LAST NAME</th> <th>FIRST NAME</th> <th>M.I.</th> <th>SOCIAL SECURITY NUMBER</th> <th>DATE OF BIRTH</th> <th><input type="checkbox"/> ADD <input type="checkbox"/> DEL.</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td><input type="checkbox"/> ADD <input type="checkbox"/> DEL.</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td><input type="checkbox"/> ADD <input type="checkbox"/> DEL.</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td><input type="checkbox"/> ADD <input type="checkbox"/> DEL.</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td><input type="checkbox"/> ADD <input type="checkbox"/> DEL.</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td><input type="checkbox"/> ADD <input type="checkbox"/> DEL.</td> </tr> </tbody> </table>										Spouse / DP	M / F	LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER	DATE OF BIRTH	<input type="checkbox"/> ADD <input type="checkbox"/> DEL.	<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/> ADD <input type="checkbox"/> DEL.	<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/> ADD <input type="checkbox"/> DEL.	<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/> ADD <input type="checkbox"/> DEL.	<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/> ADD <input type="checkbox"/> DEL.	<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/> ADD <input type="checkbox"/> DEL.
Spouse / DP	M / F	LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER	DATE OF BIRTH	<input type="checkbox"/> ADD <input type="checkbox"/> DEL.																																																		
<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/> ADD <input type="checkbox"/> DEL.																																																		
<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/> ADD <input type="checkbox"/> DEL.																																																		
<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/> ADD <input type="checkbox"/> DEL.																																																		
<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/> ADD <input type="checkbox"/> DEL.																																																		
<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/> ADD <input type="checkbox"/> DEL.																																																		
<b>6. OTHER INSURANCE—Do you or anyone on your plan have</b> Other MEDICAL Insurance? <input type="checkbox"/> YES <input type="checkbox"/> NO    Effective Date _____    Other DENTAL Insurance? <input type="checkbox"/> YES <input type="checkbox"/> NO    Effective Date _____ Name of Insurance _____    Subscriber Name _____    Name of Insurance _____    Subscriber Name _____ Subscriber DOB _____    SSN _____    Subscriber DOB _____    SSN _____ Who is covered (list) _____    Who is covered (list) _____ <b>MEDICARE A or B</b> <input type="checkbox"/> NO <input type="checkbox"/> YES—Please attach a copy of card(s) <b>MEDICARE D</b> <input type="checkbox"/> NO <input type="checkbox"/> YES—Who is covered _____    Effective Date _____																																																									
<small>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 children 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: <a href="http://www.ggusd.k12.ca.us/departments/insurance/">http://www.ggusd.k12.ca.us/departments/insurance/</a></small>																																																									
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
- **Signature Line**

**Be sure to sign and date form**

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.

<u>Relationship</u>	<u>Name</u>	<u>Social Security No.</u>	<u>Birth Date</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

---

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 \_\_\_\_\_



## 4) Retiree AB528 Dental Coverage

### Certificated

- Rate sheet provides quarterly 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.**



**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, 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
- **Turn in COBRA Acknowledgement half sheet today**



# Contact Information

## (714) 663-6523

**Kimberly I. Bessey**  
kbessey@ggusd.us

**Evette Chiang**  
echiang@ggusd.us

**Jan Hill**  
jhill1@ggusd.us