SANTA ANA UNIFIED SCHOOL DISTRICT

Retirement Benefits Application

I. RETIREE INFORMATION

Print or type in dark ink and check (✓) each applicable box

LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH	SSN OR EMPLOYEE ID #

ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE NUMBER

RETIREMENT DATE

GENDER
- ☐ Female
- ☐ Male

MARITAL STATUS
- ☐ Single
- ☐ Married
- ☐ Domestic Partnership
- ☐ Divorced
- ☐ Separated
- ☐ Widowed

CLASSIFICATION
- ☐ Certificated
- ☐ Classified
- ☐ Management

II. RETIREMENT PROGRAM REQUIREMENTS

Read the following information carefully and initial next to each statement. Your initials acknowledge the requirements listed below.

_____ *(Initial)* I acknowledge when my spouse or I become eligible for Medicare at age 65, we must enroll in hospitalization and medical (Parts A and B) and pay our portion of any Medicare premiums along with any District health insurance premium.

_____ *(Initial)* Due to Medicare guidelines, I acknowledge we will be charged a penalty by Medicare if my spouse or I do not enroll in Medicare when we become eligible for Medicare. We will also be terminated from our District coverage for not enrolling in Medicare when we become eligible.

_____ *(Initial)* Due to Medicare guidelines, I understand the District hospital and medical insurance benefits offered under the retirement program shall be supplemental to benefits provided under Medicare. Additionally, if I enroll in a non-District HMO senior advantage plan to which my Medicare is assigned there will be no medical benefits from the District retirement program.

_____ *(Initial)* I will inform the District of any change in my home address or contact telephone number. Failing to update any of my contact information may result in miscommunication and possible termination of my District coverage.

_____ *(Initial)* I will inform the District if I move out of the state of California. Additionally, I am aware of the requirement to change to a PPO plan and pay the PPO premium when moving out of the state of California.

_____ *(Initial)* I understand I will receive a monthly health insurance statement and must pay for my health insurance premiums by the date indicated on the statement. If I do not pay for my health insurance premiums by the date they are due my District coverage will be terminated for non-payment.

CERTIFICATED RETIREES ONLY

_____ *(Initial)* I understand that my health insurance premiums will be deducted from my CalSTRS retirement pension check monthly. If I refund my pension and do not inform the District, my District coverage may be terminated due to non-payment of my health insurance premiums.

With my signature below, I hereby apply for the retirement program provided under SAUSD's Administrative Regulation 4117.15.

_____ Signature _____ Date

TO BE COMPLETED BY BENEFITS OFFICE STAFF:

AGE ON RETIREMENT DATE	AGE 65 DATE
YEARS OF SERVICE	YEARS OF COVERAGE
COMMENCING	YEAR COVERAGE ENDS
APPROVED	MEDICAL / DENTAL