



# Los Angeles Unified School District Benefits Administration

**Submit completed form to:**

*(fax or email preferred)*

Fax: (213) 241-4247 or

Email: [benefits@lausd.net](mailto:benefits@lausd.net)

Benefits Administration

P.O. Box 513307

Los Angeles, CA 90051 Fax:

(213) 241-4247

## Retiree Change of Address Form

**SECTION 1: Change of Address** – Complete to update address.

EMPLOYEE # or SOCIAL SEC #	LAST NAME	FIRST NAME		MI
OLD ADDRESS (Street)	CITY	STATE	ZIP CODE	OLD PHONE #
NEW ADDRESS (Street)	CITY	STATE	ZIP CODE	NEW PHONE #

**SECTION 2: Out of Area Enrollment** – Fill this section only if you moved to another state and your current plan is not available in that state. Unless otherwise noted, plans are available in all 50 states. Coverage for every zip code, is not available in every state. Please contact provider(s) to verify if LAUSD coverage is available for your new zip code.

MEDICAL		DENTAL	VISION
<p><b><u>Under 65</u></b></p> <p><input type="checkbox"/> Anthem Blue Cross EPO</p> <p><input type="checkbox"/> Kaiser Permanente HMO (CA, HI, OR, WA only)</p> <p><input type="checkbox"/> No Medical Coverage</p>	<p><b><u>Medicare Advantage (Over 65)*</u></b></p> <p><input type="checkbox"/> Kaiser Permanente Senior Adv. (CA, HI, OR, WA only)</p> <p><input type="checkbox"/> Anthem Blue Cross EPO (Retirees with Medicare Part B only)</p> <p><input type="checkbox"/> Anthem Medicare Preferred (PPO) Medical plan** (Retirees with Medicare Parts A and B)</p> <p><input type="checkbox"/> No Medical Coverage</p>	<p><input type="checkbox"/> United Concordia® Dental PPO</p> <p><input type="checkbox"/> DeltaCare® USA DHMO</p> <p><input type="checkbox"/> No Dental Coverage</p>	<p><input type="checkbox"/> EyeMed Vision Care</p> <p><input type="checkbox"/> VSP® Vision Care</p> <p><input type="checkbox"/> No Vision Coverage</p>

\* If you are enrolling into another Medicare Advantage plan, you must first dis-enroll from your previous Medicare Advantage plan and then enroll in the new plan by completing the Group Enrollment application. Enrollment forms and contact information may be obtained at [benefits.lausd.net](http://benefits.lausd.net) under the Medicare section of Forms and Publications.

\*\* Retiree and/or their dependent must be over 65 and enrolled in Medicare Parts A and B. If dependent is under 65 or over 65 with Medicare B only, they will be enrolled in Anthem Blue Cross EPO.

I understand this election will remain in effect as long as I remain eligible or until I make another election during an annual open enrollment period. I hereby authorize any insurance company, organization, employee, hospital, physician, surgeon, or pharmacist to release any information requested to pay any claim under the plan selected. I want to enroll myself and those eligible members of my family to participate in the plan elected. I understand that it is my responsibility to report any change in the eligibility of my dependents. I also understand that I must abide by the provisions of the plan in which I enroll and that any controversy between any HMO Plan member and such HMO (including its agents, staff physicians, employees and providers) is subject to binding arbitration. I certify under penalty of perjury that the above information is true and accurate to the best of my knowledge and belief.

	Internal Use
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<b>Sign Here:</b>	DATE SIGNED	EFF DATE	DATE PROC	INITIALS
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[---- FOR OFFICE USE ONLY ----]

