County of San Luis Obispo
Retiree Medicare Eligibility Notification
ACTION REQUIRED- READ CAREFULLY

Group ID: SLO

«First_Name» «Last_Name»
«Address_1»

«City», «State» «Zip_Code»

Dear «First_Name» «Last_Name»,

The County of San Luis Obispo records indicate that you or your dependent will soon be eligible for Medicare. This notice includes important information about the availability of Medicare benefits through the County of San Luis Obispo and qualifying event information. Medicare eligibility is a qualifying event to make the following changes to your County Sponsored insurance:

- Enroll or Decline County Medicare Plan. **Note: No changes to Dental & Vision coverage can be made at this time as the Medicare transition is only a Qualifying Event for medical coverage. Changes to Dental & Vision plans should be made during the Annual Open Enrollment period.**
- Transition to a Medicare Plan with certification of enrollment in Medicare Parts A & B

Completion of the enclosed "Medicare Eligibility & Qualifying Event" form is mandatory to enroll or decline coverage. Return the enclosed form to BCC with a copy of your Medicare ID card. All mail must be postmarked prior to your birth date. Please complete, sign, and send all forms to:

Benefit Coordinators Corporation (BCC)
County of San Luis Obispo – Medicare Participants
Two Robinson Plaza, Ste. #200
Pittsburgh, PA 15205

If you choose to transition and enroll in a County Medicare plan:

- Your non-Medicare County plan will terminate at the end of the month **prior** to your 65th birthday.
- Your Medicare plan will be effective on the first day of the month of your 65th birthday.
- This special enrollment opportunity only applies to the member turning age 65 and no changes will be made to the enrollment status of any enrolled dependents

unless the County Retiree is turning Age 65. The plan options available to dependents will be dictated by the retiree's enrollment election and any impacted dependents will be transitioned automatically.

- If you are a Retiree turning 65 and have questions about your dependent's coverage refer to the Retiree Benefits Brochure for more information on how your transition will impact your dependents coverage.

If you decline County Medicare coverage or fail to reply:

- You and your dependents will not be eligible to enroll in County Medical insurance in the future.
- If you are enrolled in a non-Medicare County plan, coverage for you and any dependents will terminate at the end of the month **prior** to your 65th birthday.
- If an enrollment form is not received by BCC this will be considered opting out of County medical insurance and you will no longer be able to participate in County medical insurance in the future.

Questions about Medicare? Contact your local Social Security Administration (SSA) office.

Enrollment Questions? Contact the Retiree Enrollment Line at 1-833-574-1838

Other Questions?

HICAP at 1-800-434-0222 or Santa Maria HICAP Phone Number is (805) 928-5663.
HICAP does not sell anything but provides free and unbiased information and counseling about Medicare so you can make informed decisions. The Health Insurance Counseling & Advocacy Program is a statewide network of nonprofit organizations authorized by state legislation originally authored in 1985 to provide free, independent, unbiased information and is the only agency authorized by the California Department of Aging to provide Medicare counseling. HICAP is funded through the Older Californians Act from the Area Agency on Aging and State Health Insurance Assistance Program (SHIP) funding from the Administration for Community Living (ACL).

Additionally, you can call Alliant Medicare Solutions (AMS) at (866) 273-6420 to speak to a licensed Insurance Agent. AMS can help you with questions on your current insurance coverage, types of coverage that are offered by the County, original Medicare, Medigap, Medicare Advantage, and prescription drug plans. AMS is here to help you find which plans might be the best for you!

Contact the County of San Luis Obispo Human Resources at 805-781-5959, hrbenefits@co.slo.ca.us or visit www.slocounty.ca.gov/benefits webpage for complete plan documents.

Age 65 Notification
Medicare Eligibility & Qualifying Event Form

Section 1: MEMBER ENROLLMENT OR CHANGE – COMPLETE IN FULL

NAME (last, first, MI):	SOCIAL SECURITY #:	BIRTH DATE (mm/dd/yyyy):	☐ MALE ☐ FEMALE ☐ NONBINARY
HOME PHONE:	WORK PHONE:	E-MAIL ADDRESS:	
HOME ADDRESS, CITY, STATE, ZIP (PO Box may NOT be used):			
MAILING STREET ADDRESS, CITY, STATE, ZIP (PO Box may be used):			

MARITAL STATUS:	☐ SINGLE	☐ MARRIED	☐ LEGALLY SEPARATED
	☐ DOMESTIC PARTNER	☐ DIVORCED	

Section 2: FOR MEMBER/DEPENDENT TO ENROLL IN MEDICARE COORDINATION PLAN OR WAIVE MEDICAL INSURANCE

☐ Enroll in County Sponsored Medicare Plan

☐ Decline Medicare Coverage and Opt Out **– Skip to Section 5**

Section 3: FOR MEMBER/DEPENDENT ENROLLED IN MEDICARE PARTS A AND B

☐ I certify that I am enrolled in Medicare Parts A and B. I have a copy of my Medicare Card. This is the information shown on my red, white, and blue Medicare Card or Notice of Entitlement from the Social Security Administration (SSA).

☐ I understand that I am <u>required</u> to include a copy of my Medicare ID Card with this completed form.

NAME OF MEDICARE BENEFICIARY:
MEDICARE CLAIM NUMBER (HICN):
HOSPITAL (PART A) EFFECTIVE DATE:
MEDICAL (PART B) EFFECTIVE DATE:
I WOULD LIKE TO ENROLL IN THE FOLLOWING MEDICARE COORDINATION BENEFIT PLAN: ☐ Anthem Medicare PPO ☐ Anthem Medicare EPO

Age 65 Notification
Medicare Eligibility & Qualifying Event Form

Section 4: TO ENROLL IN MEDICARE COORDINATION PLAN – SIGNATURE REQUIRED

I declare that the information given on this form is true and complete to the best of my knowledge and belief. I understand that the information I have provided is the basis on which coverage may be issued under these plans. Any misstatements or omissions may result in future claims being denied and/or my coverage(s) being rescinded.

SIGNATURE:	**DATE:**

Section 5: TO WAIVE OR OPT OUT OF COUNTY MEDICAL - SIGNATURE REQUIRED
Complete Only if Declining Coverage

I understand that I am eligible for medical and pharmacy coverage through my former employer. I waive the right to enroll in the medical plan and pharmacy plans offered to me by my former employer for the following reason (please check one):

☐ I am covered under another Medicare Advantage/Supplement Plan
☐ I am covered through my spouse's employer
☐ I have no other coverage, but choose not to enroll

I understand that by declining coverage, myself or my dependents are no longer eligible to enroll in the County's medical insurance plans in the future and that if I am currently enrolled in a County medical plan it will terminate at the end of the month prior to my 65th birthday.

SIGNATURE:	**DATE:**