PERALTA COMMUNITY COLLEGE DISTRICT
RETIREE HEALTH REQUEST FORM FOR REIMBURSEMENT

Please use a separate claim for each healthcare professional and for each individual covered. Please provide itemized bill(s) for each claim.

Retiree Information			
Retiree's Full Name:	Date of Birth:	Retiree's Mailing Address:	
Retiree's Primary Telephone Number:	Retiree's Most Recent Date of Hire with Peralta Community College District:	Retiree's Date of Retirement from Peralta Community College District:	Retiree's Peralta Community College District Job Title at Retirement:
Retiree's Current Health Insurance Plan and Level of Coverage (Select one):	☐ Anthem Medical ☐ Anthem Prescription ☐ Kaiser Medical ☐ Kaiser Prescription ☐ Other: _____		
Patient Information (Complete only if Patient is not the Retiree)			
Patient's Name (First and Last):	Patient's Relationship to Retiree:	Patient's Date of Birth:	Patient's Primary Telephone Number:
Patient's Mailing Address:			
Accident or Occupational Claim Information			
Is this claim a result of an accident or illness due to employment?			
Is this claim a result of an injury due to an auto accident?			
Is the retiree or dependent filing a Workers' Compensation claim, insurance claim or lawsuit to cover the costs of this claim? If so, please describe.			
Other Coverage Information:			
Is the patient covered under another health insurance plan?			

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If yes, please provide the type of plan and coverage information.	
If the patient is covered under another health insurance plan, has the retiree or dependent filed a claim for reimbursement of costs under that plan?	

Explanation

Please explain the difference between current health insurance coverage and coverage provided to the retiree or dependent at the time of the retiree's retirement from the District (or upon eligibility for Medicare, where applicable for employees hired before July 1, 2004). Please include a detailed explanation for why the retiree is entitled to District reimbursement beyond what the current health insurance plan provides. (Please use a separate sheet if needed).

Certification

I certify that the information I have supplied on this form is true and correct. I further certify that reimbursements requested do not include any amounts that have been reimbursed or covered by insurance, a flexible spending account, or other plan.

SIGNATURE:	
DATE:	