Los Angeles Unified School District
Benefits Administration

Retiree Change of Address Form

Submit completed form to:
(fax or email preferred)
Fax: (213) 241-4247 or
Email: benefits@lausd.net

Benefits Administration
P.O. Box 513307
Los Angeles, CA 90051

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

Employee No. or Social Security No.	Last Name	First Name	MI

OLD Address (Street)	City	State	Zip Code	OLD Phone Number
NEW Address (Street)	City	State	Zip Code	NEW Phone Number
Email Address				

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
Under 65	**Medicare Plans (Over 65)** *		
☐ Anthem Blue Cross EPO	☐ Kaiser Permanente Senior Adv. (HI, WA, OR with Medicare Parts A and B)	☐ Aetna Dental PPO	☐ EyeMed Vision Care
☐ Kaiser Permanente HMO (CA, HI, WA, OR only)	☐ Anthem Blue Cross EPO (Retirees with Medicare Parts B only)	☐ DeltaCare® USA DHMO	☐ VSP® Vision Care
☐ No Medical Coverage	☐ Anthem Medicare Preferred (PPO) (Retirees with Medicare Parts A and B)**	☐ No Dental Coverage	☐ No Vision Coverage
	☐ No Medical Coverage		

* If you are enrolling into another Medicare Advantage plan, you must dis-enroll from your previous Medicare Advantage plan. Dis-enrollment forms and contact information may be obtained at lausd.org/benefits/forms under the Medicare section of Forms and Publications.

** Retiree and/or their dependent must be enrolled in Medicare Parts A and B. If dependent is under 65 or Medicare eligible with Part B only, then the dependent 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

Applicant's Signature		**DATE**	**EFF DATE**	**DATE PROC**	**INITIALS**

[---- FOR OFFICE USE ONLY ----]