

**FOOTHILL-DE ANZA COMMUNITY COLLEGE DISTRICT**

**Request For Continuing Health Coverage  
MEDICAL/DENTAL/VISION/EAP**

NAME OF PERSON TO BE INSURED (please print): \_\_\_\_\_

SOCIAL SECURITY NUMBER (required): \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

ADDRESS OF THE PERSON TO BE INSURED: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_ E-MAIL: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ DAY TIME PHONE: \_\_\_\_\_

**LIST ANY ADDITIONAL DEPENDENTS TO BE INSURED**

1. Spouse \_\_\_\_\_ DOB: \_\_\_\_\_ SSN \_\_\_\_\_

2. Dependent \_\_\_\_\_ DOB: \_\_\_\_\_ SSN \_\_\_\_\_

3. Dependent \_\_\_\_\_ DOB: \_\_\_\_\_ SSN \_\_\_\_\_

4. Dependent \_\_\_\_\_ DOB: \_\_\_\_\_ SSN \_\_\_\_\_

**QUALIFYING EVENT REQUEST** (please select one):

- 1. Termination of employment
- 2. Death of subscriber
- 3. Divorce or legal separation
- 4. Approve leave without pay
- 5. Reduction in hours of employment
- 6. Dependent reached age limit according to PLAN

**COVERAGE TO BE CONTINUED:** You may choose (A) **Medical and Prescription - sponsored by CalPERS**, (B) **Employee Assistance Program Only** or (C) **Dental only**, or (D) **Vision only**, or (E) **Dental & Vision only**, or (F) the **Entire Package** of Medical, Prescription, Employee Assistance Program, Dental and Vision. Please enter the \$\$\$\$ premium at far right for the coverage you wish to continue:

	<b>MONTHLY PREMIUM/PERSON</b>	<b>MONTHLY PREMIUM</b>
<b>*Medical:</b>	COBRA rates varied by Plan, please refer to CalPERS published rates X 102% \$ _____	
<b>Dental:</b>	Insured only	\$ 76.86 \$ _____
	Insured + one	\$ 153.73 \$ _____
	Insured + two or more	\$ 215.22 \$ _____
<b>Vision:</b>	Insured only	\$ 10.13 \$ _____
	Insured + one	\$ 20.26 \$ _____
	Insured + two or more	\$ 28.37 \$ _____
<b>E.A.P.:</b>	Insured only	\$ 3.25 \$ _____
	Insured + one	\$ 3.25 \$ _____
	Insured + two or more	\$ 3.25 \$ _____
<b>TOTAL MONTHLY PREMIUM:</b>		<b>\$ _____</b>

**\*Medical premium is processed by CalPERS and billed directly to you by insurance carriers, not by FHDA.**

**\*\* NOTE: PREMIUM IS SUBJECT TO CHANGE EACH JANUARY 1<sup>st</sup> \*\***

The premium is charged to the insured beginning on the day following the **QUALIFYING EVENT** (the day after your **DISTRICT** paid benefits expire). There can be **NO BREAK IN COVERAGE**. The first payment including any payment **retroactive** to the first day of Continued Coverage is **DUE ON** or **BEFORE** the **45<sup>th</sup>** day this Request for Coverage is received in the District Office. Subsequent payments are due in the District Office on the first day of each month. Failure to submit payment in a timely manner will result in termination of coverage without reinstatement rights. All claims will be **"PENDING"** until payment is received.

This REQUEST FOR CONTINUING HEALTH COVERAGE must be received by the District Office of Human Resources on or before \_\_\_\_\_ or the offer of the coverage is void.

SIGNATURE OF INSURED ADULT: \_\_\_\_\_ DATE: \_\_\_\_\_

**SIGNATURE OF LEGAL GUARDIAN WHO WILL BE PAYING THE PREMIUM OF ABOVE INSURED MINOR(S):**  
SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_

STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_ PHONE: \_\_\_\_\_ E-Mail: \_\_\_\_\_