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: _____

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:

		MONTHLY PREMIUM/PERSON	MONTHLY PREMIUM
***Medical**:	COBRA rates varied by Plan, please refer to CalPERS published rates X 102%		$_____
Dental:		Insured only	$_____
		Insured + one	$_____
		Insured + two or more	$_____
Vision:		Insured only	$_____
		Insured + one	$_____
		Insured + two or more	$_____
E.A.P.:		Insured only	$_____
		Insured + one	$_____
		Insured + two or more	$_____
		TOTAL MONTHLY PREMIUM:	**$**_____

***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 1st ****

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 **45th** 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:_____