

**FOOTHILL-DE ANZA COMMUNITY COLLEGE DISTRICT**

**Request For Continuing Health Coverage  
EXCLUSIVE PROVIDER ORGANIZATION (EPO) MEDICAL PLAN/E.A.P./DENTAL/VISION**

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  | 5. Change of employment hours                              |
| 2. Marriage of covered child  | 6. Retirement (when ineligible for District paid benefits) |
| 3. Death of subscriber  | 7. Dependent reached age limit according to PLAN           |
| 4. Dependent can no longer be claimed for tax<br>purpose according to the IRS | 8. Divorce or legal separation                             |

**COVERAGE TO BE CONTINUED:** You may choose (A) **Medical, Prescription and Employee Assistance Program Only** or (B) 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
EPO Medical/Rx/E.A.P.:	Insured only	\$ 773.99
	Insured + one	\$1,544.80
	Insured + two or more	\$2,167.98
Dental & Vision:	Insured only	\$ 73.73
	Insured + one	\$ 147.11
	Insured + two or more	\$ 185.39
TOTAL MONTHLY PREMIUM:		\$ _____

**\*\* NOTE: PREMIUM IS SUBJECT TO CHANGE EACH JULY 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: \_\_\_\_\_