# FOOTHILL-DE ANZA COMMUNITY COLLEGE DISTRICT

## Request For Continuing Health Coverage
## (KAISER MEDICAL PLAN, Employee Assistance Program, Dental and 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
2. Marriage of covered child
3. Death of subscriber
4. Dependent can no longer be claimed for tax purpose according to the IRS
5. Change of employment hours
6. Retirement (when ineligible for District paid benefits)
7. Dependent reached age limit according to PLAN
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** |
|---|---|---|---|
| KAISER MED/Rx/E.A.P.: | Insured only | $ 553.84 | $_____ |
| | Insured + one | $1,104.42 | $_____ |
| | Insured + two or more | $1,561.41 | $_____ |
| DENTAL/VISION: | Insured only | $ 81.21 | $_____ |
| | Insured + one | $ 162.41 | $_____ |
| | Insured + two or more | $ 227.37 | $_____ |
| TOTAL MONTHLY PREMIUM: | | | **$**_____ |

**** NOTE: PREMIUM IS SUBJECT TO CHANGE EACH JULY 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:_____