## FOOTHILL-DE ANZA COMMUNITY COLLEGE DISTRICT

## Request For Continuing Health Coverage EXCLUSIVE PROVIDER ORGANIZATION (EPO) MEDICAL PLAN

4. Dependent	NAME OF PERSON TO BE INSURED (plea	ase print):		
CITY:STATE:ZIP CODE:B-MAIL:	SOCIAL SECURITY NUMBER (required):		DATE OF BIRTH:	
LIST ANY ADDITIONAL DEPENDENTS TO BE INSURED	ADDRESS OF THE PERSON TO BE INSUR	RED:		
LIST ANY ADDITIONAL DEPENDENTS TO BE INSURED  1. Spouse	CITY:STA	TE:ZIP CODE	:E	S-MAIL:
2. Dependent	HOME PHONE:		DAY TIME PHONE:	
2. Dependent DOB: SSN  3. Dependent DOB: SSN  4. Dependent DOB: SSN  DOB: SSN  OUALIFYING EVENT REQUEST (please select one):  1. Termination of employment S. 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 8. Divorce of legal separation  COVERAGE TO BE CONTINUED: You may choose Medical and Prescription Program Only. Please enter the \$\$\$ premium at far right for the coverage you wish to continue:  MONTHLY PREMIUM/PERSON DESIRE PREMIUM/MONTH  MEDICAL & PRESCRIPTION: Insured only \$ 713.21 \$ Insured + one \$1.426.41 \$ Insured + one	LIST AN	NY ADDITIONAL DE	EPENDENTS TO BE I	<u>NSURED</u>
3. Dependent	1. Spouse		DOB:	SSN
QUALIFYING EVENT REQUEST (please select one):  1. Termination of employment	2. Dependent		DOB:	SSN
OUALIFYING 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  COVERAGE TO BE CONTINUED: You may choose Medical and Prescription Program Only. Please enter the \$\$\$ premium at far right for the coverage you wish to continue:    MONTHLY PREMIUM/PERSON   DESIRE PREMIUM/MONTH	3. Dependent		DOB:	SSN
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Insured + one	right for the continue.	MONTHLY PRE	MIUM/PERSON	DESIRE PREMIUM/MONTH
** 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:  DATE:	MEDICAL & PRESCRIPTION:	Insured + one	\$1,426.41	
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benefits expire). There can be <b>NO BREAK IN COVERAGE.</b> The first payment including any payment <b>retroactive</b> to the first day of Continued Coverage is <b>DUE ON</b> or <b>BEFORE</b> the <b>45</b> <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 " <b>PENDING</b> " 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:	** NOTE: Pl	REMIUM IS SUBJEC	CT TO CHANGE EAC	H JULY 1st **
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SIGNATURE:DATE:	SIGNATURE OF INSURED ADULT:			DATE:
	SIGNATURE OF LEGAL GUARDIAN W	HO WILL BE PAYIN	NG THE PREMIUM O	OF ABOVE INSURED MINOR(S):
ADDRESS:CITY:	SIGNATURE:		DA	ATE:
	ADDRESS:		CITY:	

\_\_E-Mail:\_\_\_

STATE: \_\_\_\_\_PHONE:\_\_\_\_