

FOOTHILL-DE ANZA COMMUNITY COLLEGE DISTRICT
Request For Continuing Health Coverage
PREFERRED PROVIDER ORGANIZATION (PPO) MEDICAL PLAN

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 purpose according to the IRS | 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	\$ 835.36
	Insured + one	\$1,670.72
	Insured + two or more	\$2,346.17
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: _____