FOOTHILL-DE ANZA
Community College District

REQUEST TO CHANGE BENEFIT PLAN FORM
for
COBRA ENROLLEES ONLY

IMPORTANT: COMPLETE THIS FORM *ONLY IF*
YOU WISH TO CHANGE MEDICAL PLANS OR DELETE/ADD DEPENDENT(S).
FOR 2011/2012, COBRA ENROLLEES ARE **DEFAULTED** TO THE CURRENT PLAN AND LEVEL OF COVERAGE.
DO NOT COMPLETE THE FORM IF YOU WANT TO RETAIN THE SAME BENEFITS AND LEVEL OF COVERAGE!

If you wish to change plan or level of coverage, please make your selection for the Plan Year 2011/2012 (July 2011 – June 2012) below.

Circle the option to change your current benefit coverage:

	PLAN OF SELECTION FOR PY 2011/2012	MONTHLY PREMIUM FOR SINGLE INSURED	MONTHLY PREMIUM FOR INSURED + ONE DEP	MONTHLY PREMIUM FOR INSURED + 2 or More DEP
Option #1	KAISER/EAP	$553.75	$1,104.33	$1,561.32
Option #2	EPO/Rx/EAP	$681.23	$1,359.30	$1,901.76
Option #3	PPO/Rx/EAP	$1,013.15	$2,023.14	$2,831.13
Option #4	KAISER/EAP/DENTAL/VISION	$634.95	$1,266.74	$1,788.70
Option #5	EPO/Rx/EAP/DENTAL/VISION	$762.44	$1,521.71	$2,129.13
Option #6	PPO/Rx/EAP/DENTAL/VISION	$1,094.35	$2,185.55	$3,058.51

The effective date of medical coverage for all changes made during this Open Enrollment will be July 1, 2011.

COBRA ENROLLEE NAME: _____ SSN _____ DOB: _____

DEPENDENT NAME: _____ SSN _____DOB: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP _____

PHONE: _____ EMAIL ADDRESS: _____

_____ _____
COBRA Enrollee Signature Date

DEADLINE: Return the form to the District by Friday, April 29, 2011 @ 5:00pm

Mail your form to: **Foothill - De Anza Community College District**
Attn: BENEFITS UNIT
12345 El Monte Rd
Los Altos Hills, CA 94022
Fax # (650) 949-2831
PDF/Email: MyBenefits@fhda.edu

Do NOT turn in this form if you wish to keep the same benefits plan and dependent coverage level as last year.