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## IMPORTANT: ACTION REQUIRED FOR DEPENDENT COVERAGE

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September 1, 2010

Dear Employee:

The District is committed to offering employees affordable and competitive benefits. To ensure that only eligible dependents are enrolled and to meet health plan contract obligations, the District must verify family member eligibility. You are being contacted because you have a spouse/dependent child(ren) enrolled in District health benefits. In order to continue coverage for your dependent(s), you **must** provide the following to prove that your dependents are eligible according to the Plan eligibility requirements.

You must provide proof of eligibility for the person(s) listed on the enclosed *Verification Form for Dependent Eligibility* to Secova, no later than **September 30, 2010**. Failure to provide the necessary documentation by September 30, 2010 will disqualify the dependent for coverage for the Plan Year 2010-2011.

### Your Privacy

Secova enforces a strict company privacy policy for the handling of your documents and communications that may contain sensitive information. We ensure that the information you submit, in all forms, including paper, electronic, and telephonic, remains secure. We require all employees at Secova to complete HIPAA (Health Insurance Portability and Accountability Act) data security management training and employees are regularly audited on their compliance with PHI (Protected Health Information) privacy requirements.

### What You Need to Do

**Please complete the following steps for your dependent(s) currently enrolled in The District healthcare coverage.**

- **REVIEW** the enclosed *Definitions and Required Documents* to confirm your dependents meet the eligibility requirements and to identify what documentation you are required to submit; **AND COMPLETE THE FOLLOWING STEPS:**
  1. **VISIT** The District Dependent Eligibility Verification website @ <https://verify.secova.com/fhda> for instructions on verifying dependent eligibility online; **OR**
  2. **OBTAIN** the appropriate documentation for each dependent and make copies; **AND**
  3. **WRITE** your name and Employee ID# in the top right hand corner of each document you submit. See the enclosed *Verification Form for Dependent Eligibility* for your Employee ID#; it is in the upper right hand corner above the bar code; **AND**
  4. **COMPLETE, SIGN AND DATE** the enclosed *Verification Form for Dependent Eligibility*; **AND**
  5. **MAIL** the completed and signed *Verification Form for Dependent Eligibility* with copies of required eligibility documentation, **OR FAX** your documents to Secova at 1-866-585-6860 no later than June 15, 2010. A postage-paid envelope is enclosed for your convenience. If you mail the form, please keep a copy for your records.

**If you have questions,  
please call Secova at  
1-866-364-2594 (toll-free).  
Representatives are available  
Monday through Friday  
8:00AM to 6:00PM PST.  
Your call is confidential.**

If you fax the documents to Secova, please retain a copy of the fax transmission confirmation for your records. If you mail the forms, you may want to obtain a proof of mailing from the USPS, or you may send it certified mail.

Upon completion of the verification process, you will receive confirmation on the verification status of your dependent(s) from Secova. If you have any questions during this process please **contact Secova at 1-866-364-2594 (Representatives are available Monday through Friday 8:00 AM- 6:00 PM PST), or you may send an email to [fhda.benefits@secova.com](mailto:fhda.benefits@secova.com).**

**If you do not sign and return the Verification Form and Required Documents to Secova by September 30, 2010, your dependents will be removed from your coverage effective September 30, 2010.**

Your cooperation during this process allows us to maintain the integrity of our benefit programs and continue to provide cost-effective coverage for our employees. Thank you for your time and responsiveness to ensure your District health benefits coverage continues for your dependent(s).

Sincerely,

A handwritten signature in black ink, appearing to read "Christine Vo", followed by a horizontal line.

Christine Vo  
Benefits Manager