FOOTHILL-DE ANZA
Community College District

Office of Human Resources and Equal Opportunity
12345 El Monte Road, Los Altos Hills, CA 94022

IMPORTANT: ACTION REQUIRED FOR DEPENDENT COVERAGE

Dear Employee: May 27, 2009

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 to Secova, no later than **June 15, 2009**. Failure to provide the necessary documentation by June 15, 2009 will disqualify the dependent for coverage for the Plan Year 2009-2010.

Please complete the following steps to submit verification documentation for your dependent(s) currently enrolled in the District's health benefits program to ensure your enrolled dependent(s) remain covered under your benefits plan:

OPTION #1:

* **ACCESS** the District's Dependent Eligibility Verification web site at **https://verify.secova.com/fhda** for instructions on verifying dependent eligibility on-line; **OR**

OPTION #2:

* **REVIEW** the enclosed Dependent Eligibility Definitions and Required Documentation to confirm that your dependent(s) meets eligibility criteria and to identify what document(s) you are required to submit.

a) SECURE the appropriate documentation for each dependent and make copies. Please write your name and Employee ID# in the top right hand corner of each document. *(See the enclosed Verification Form for your Employee ID#.)*

b) COMPLETE, SIGN AND DATE the enclosed Verification Form.

c) MAIL the completed and signed Verification Form with copies of required eligibility documentation to Secova in the enclosed postage-paid envelope, or **fax your documents to Secova at 1-866-585-6860** or **pdf the documents and send via email to**: **fhda.benefits@secova.com** no later than **June 15, 2009**. Please remember to write your **full name** and **FHDA Verification Number *(Last 4 digits of your Social Security Number, followed by your date of birth: SSN#MMDDYYYY)*** in the top right hand corner of each document copy.

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 via 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 M-F 8:00 AM- 6:00 PM PST), or you may send an email to fhda.benefits@secova.com.**

If you do not sign and return the Verification Form and Required Documents to Secova by JUNE 15, 2009, your dependents will be removed from your coverage effective June 30, 2009.

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,

Christine P. Vo

Christine Vo
Benefits Manager