FOOTHILL-DE ANZA COMMUNITY COLLEGE DISTRICT

Request For Continuing Health Coverage
MEDICAL/DENTAL/VISION/EAP

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
2. Death of subscriber
3. Divorce or legal separation
4. Approve leave without pay
5. Reduction in hours of employment
6. Dependent reached age limit according to PLAN

COVERAGE TO BE CONTINUED: You may choose (A) **Medical and Prescription - sponsored by CalPERS, (B) Employee Assistance Program Only** or (C) **Dental only**, or (D) **Vision only**, or (E) **Dental & Vision only**, or (F) the **Entire Package** of Medical, Prescription, Employee Assistance Program, Dental and Vision. Please enter the $$$$ premium at far right for the coverage you wish to continue:

		MONTHLY PREMIUM/PERSON	MONTHLY PREMIUM
***Medical**:	COBRA rates varied by Plan, please refer to CalPERS published rates X 102%		$__________
Dental:	Insured only	$ 76.86	$__________
	Insured + one	$ 153.73	$__________
	Insured + two or more	$ 215.22	$__________
Vision:	Insured only	$ 10.13	$__________
	Insured + one	$ 20.26	$__________
	Insured + two or more	$ 28.37	$__________
E.A.P.:	Insured only	$ 3.25	$__________
	Insured + one	$ 3.25	$__________
	Insured + two or more	$ 3.25	$__________
	TOTAL MONTHLY PREMIUM:		**$**__________

***Medical premium is processed by CalPERS and billed directly to you by insurance carriers, not by FHDA.**

**** NOTE: PREMIUM IS SUBJECT TO CHANGE EACH JANUARY 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:______________