FOOTHILL-DE ANZA COMMUNITY COLLEGE DISTRICT

Request For Continuing Health Coverage (KAISER MEDICAL PLAN, Employee Assistance Program, Dental and Vision)

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					DATE OF BIRTH:
ADDRESS OF THE PERSON TO BE I	NSURED:				
CITY:	STATE:	ZIP CODE:		E-N	MAIL:
HOME PHONE:			DAY TIME PHONE:		
LIST	Γ ANY ADD	DITIONAL DEP	PENDEN	TS TO BE INS	SURED
1. Spouse			DOB:		SSN
2. Dependent			DOB:		SSN
3. Dependent			DOB:		SSN
4. Dependent			DOB:		SSN
QUALIFYING EVENT REQUEST (p	olease select (one):			
1. Termination of employment 2. Marriage of covered child 3. Death of subscriber 4. Dependent can no longer be claimed for tax purpose according to the IRS			5. Change of employment hours6. Retirement (when ineligible for District paid benefits)7. Dependent reached age limit according to PLAN8. Divorce or legal separation		
the Entire Package of Medical, Prescri	iption, Emplo	hoose (A) Medic oyee Assistance	c al, Presc Program,	cription and E 1 , Dental and Vi	mployee Assistance Program Only or (B) sion. Please enter the \$\$\$ premium at far
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STATE: ____ZIP CODE: ___PHONE: ____E-Mail: ____