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 8, 2008

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 6, 2008**. Failure to provide the necessary documentation will disqualify the dependent for coverage and re-enrollment will not be allowed until the next plan year. In addition, employees may be responsible for any employer contributions to and benefits paid by the plan for ineligible coverage.

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:

1. **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.
2. **SECURE** the appropriate documentation for each dependent and make copies.
3. **COMPLETE, SIGN AND DATE** the enclosed Verification Form.
4. **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** no later than **June 6, 2008**. 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: SSNMMDDYYY)*** in the top right hand corner of each document copy. If you mail the form, please keep a copy for your records.

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 6, 2008, your dependents will be removed from your coverage effective June 30, 2008.

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 Vo
Benefits Manager