[redacted]

FOOTHILL-DE ANZA
Community College District

Return form to Secova via mail or fax by June 6, 2008

MAIL: Return in the enclosed postage-paid envelope or mail to the following address:

Secova Western Service Center
PO Box 5080
Costa Mesa, 92628
FAX: 1-866-585-6860

FHDA Verification Number *(Last 4 digits of your SSN#, followed by your date of birth: SSNMMDDYYYY)*	
Employee Name	
Address	
City, State, Zip Code	

Instructions:
Please list below all dependents currently enrolled in your District medical, dental, vision care and life insurance coverage. You **MUST** provide the required documentation verifying dependent eligibility for any dependent(s) listed below by **June 6, 2008.** If you select "no" or do not respond, your dependent(s) coverage will be dropped effective **June 30, 2008.**

- **Review** the Definition of Eligible Dependents
- **Verify** each dependent's eligibility for benefits by checking "yes" or "no" on this form
- **Review** the Required Documents list for each dependent type currently enrolled
- **Return** this completed and signed Verification Form, along with Required Documentation, to Secova by mail using the enclosed postage-paid envelope or fax to 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: SSNMMDDYYYY) in the top right hand corner of each document copy.***

Dependent	Relationship to you	Is this dependent eligible for coverage?
		Yes ☐ No ☐
		Yes ☐ No ☐
		Yes ☐ No ☐
		Yes ☐ No ☐
		Yes ☐ No ☐
		Yes ☐ No ☐

Contact information
Please provide a telephone number at which you can be reached if we have questions about your dependent's eligibility for benefits coverage. An email confirmation will be sent to you upon receipt of your completed form.

Telephone: (_____)_____ Best time to call: **Day** **Evening**

E-mail address: _____ *(circle one)*

I declare that the attached information I am submitting to prove eligibility for my spouse and/or dependent child(ren) under the District's benefit plans is true, accurate, and complete. I understand that if I have provided false, incomplete or misleading information, or if I fail to update this information in accordance with eligibility guidelines, I may be subject to the following: reduced coverage levels, repayment of any claims or premiums paid by the District, termination of dependent(s) District benefit coverage.

_____ _____
Signature Date

If you have questions, please call Secova at 1-866-364-2594, M-F 8:00 AM- 6:00 PM PST