Health Care Plan Extension Request for dependents
(This Form Expires June 30, 2012)

_____ _____
Employee Name Soc. Sec. No.

_____ _____
Employing Unit City

I hereby request an extension of coverage for my dependent _____ under the Diocese of Rockford Health Care Plan beginning _____, and ending _____ (a maximum of one year). I understand that I am responsible to my employer for the payment of premiums prior to each month for which I request coverage, and that failure to make payment will terminate coverage immediately. I also understand that the Insurance Trust reserves the right to refuse coverage beyond the first 3 months when circumstances create excessive risk to the Health Care Plan.

Please state reason you are unable to obtain other coverage.

_____
_____
_____

_____ _____
Employee Signature Date

_____ _____
Employer Signature Date

Rates are subject to change without prior notice. Current rates are as follows:

1st 3 months - no additional cost

4th - 12 month - $84.00 additional per month

Instructions to employee:
After completing and signing this form, give it to your employer.

Instructions to employer:
Sign and forward to:

Diocese of Rockford Health Insurance Office, PO Box 7044, Rockford IL 61125
Notify your bookkeeping department to arrange for premium payments

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