

**Catholic Diocese of Rockford  
Health Care Plan Extension Request**  
(This Form Expires June 30, 2012)

\_\_\_\_\_  
Employee Name

\_\_\_\_\_  
Soc. Sec. No.

\_\_\_\_\_  
Employing Unit

\_\_\_\_\_  
City

I hereby request an extension of coverage under the Diocese of Rockford Health Care Plan beginning \_\_\_\_\_, and ending \_\_\_\_\_ (a maximum of one year). I understand that I am responsible to my former employer for the payment of premiums prior to each month for which I request coverage, and that failure to make payment will terminate my 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.

The Life Insurance benefit is based on the retirement amount of coverage provided.

Please state reason you are unable to obtain other coverage.

\_\_\_\_\_

\_\_\_\_\_

I elect **not** to continue health care coverage.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employer Signature

\_\_\_\_\_  
Date

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

<u>Type of Coverage</u>	<u>Rate for 1<sup>st</sup> 3 Months of ext.</u>	<u>Rate for 4<sup>th</sup> thru 12<sup>th</sup> month</u>
Individual Coverage	\$722 per month	\$900 per month
<i>Ind. &amp; Family Coverage</i>	<i>\$1,298 per month</i>	<i>\$1,622 per month</i>
Women Religious	\$708 per month	\$886 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 Care Plan, PO Box 7044, Rockford IL 61125  
Notify your bookkeeping department to arrange for premium payments