Health Insurance

Diocese of Rockford

555 Colman Center Dr.
P.O. Box 7044
Rockford, IL 61125

(815) 399-4300
Fax: (815) 997-5225

Health Care Plan Extension Request
(This Form Expires June 30, 2020)

________________________________ ____________________________
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 three months). I understand that I am responsible to my former employer for the full payment of premiums as indicated below prior to each month for which I request coverage, and that failure to make payment will terminate my coverage immediately. This three-month period allows time for my dependent(s) to obtain other health insurance coverage.

_________________________________ ______________________
Employee Signature Date

_________________________________ ______________________
Employer Signature Date

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

Dependent coverage: $761 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

EXT. DEP. REV 7/18