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 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 me, the employee, to obtain other health insurance coverage.

The Life Insurance benefit is portable or convertible Contact the health insurance office immediately. Your request must be made within 30 days of your termination.

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

☐ I am retiring with at least 30 years full-time service with the Diocese of Rockford.

_____ _____
Employee Signature Date

_____ _____
Employer Signature Date

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

Type of Coverage	Monthly Rate.
Individual Coverage	$951 per month
Ind. & Family Coverage	*$1712 per month*
Women Religious	$932 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