



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, 2021)

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: \$769 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