Diocese of Rockford

Health Insurance

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

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

Health Care Plan Extension Request – Dependent Only
(This Form Expires June 30, 2024)

_____ _____
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.

The Life Insurance benefit is portable or convertible to an individual policy. Contact the health insurance office for details. You and your dependents must apply for individual life insurance under this lif conversion privilege and pay the first premium within 31 days after the date your employment terminates.

_____ _____
Employee Signature Date

_____ _____
Employer Signature Date

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

Dependent coverage: $800 per month

Instructions to employee: After completing and signing this form, give it to your employer.
Instructions to employer: Sign and return to the Diocese via email, fax or mail to:

Diocese of Rockford Health Care Plan, PO Box 7044, Rockford IL 61125
Notify your bookkeeping department to arrange for premium payments.