ALAMEDA COUNTY SCHOOLS INSURANCE GROUP

P.O. BOX 2487 • DUBLIN, CA 94568 • 925-225-1030 • Fax 925-225-0653

Employee Notice/Election

Date_____

Employee Name_____ School District_____

Street Address_____ Social Security No._____

City, State, Zip_____ Employee I.D. No._____

This is to remind you that even though you are no longer eligible to be covered under the School District's Employee Health Plan as of _____, you have the option to continue your benefits under the plan beyond this date. If you have dependents who were covered under the plan, you also have the option to continue their benefits.

You have 60 days from the date of this notice to notify us of your election.

If you elect this option, the benefits will be continued until:

- the expiration of 18 months following _____;
- you become a covered employee under any group health plan;
- you or your dependent(s) become eligible for Medicare;
- you fail to pay the monthly charge for this coverage on time; or
- our Employee Health Plan is no longer in force

whichever occurs first.

The current monthly charge is:

	Yourself	Dependents	Plan Name
MEDICAL	$_____	$_____	_____
DENTAL	$_____	$_____	_____
OTHER	$_____	$_____	_____

Your first payment will be for the period beginning on_____ and ending on_____.

Therefore, the amount due will be $_____ for you, plus $_____for your dependents, if you also wish to continue their benefits.

Your first payment must be received within 45 days of the date you sign this election form. Subsequently, you will be billed monthly. Each bill will indicate the amount due, the due date, and where to send your payment. If your first payment, or any subsequent monthly payment, is not received on time, you will lose your option to continue coverage.

Please complete the bottom portion of this form.
Keep the pink copy for your records and **return the white (original) and yellow copies** to:

_____

I wish to continue my employee benefits under your Employee Health Plan.	☐ Yes	☐ No
I wish to continue my dependent benefits under the above plan.	☐ Yes	☐ No
My first payment is enclosed.	☐ Yes	☐ No
You will receive my first payment within 45 days.	☐ Yes	☐ No

Signature_____ Date_____

IMPORTANT— We ***must*** receive: 1. The completed white (original) and yellow copies of this notice by_____.
2. Your first payment within 45 days following the date you sign this form.

Print Form