san josé·evergreen
COMMUNITY COLLEGE DISTRICT

HUMAN RESOURCES SERVICES GROUP

▪ Forty South Market Street, San Jose CA 95113 408-270-6406 ▪ 408-239-8804 (fax)

Dear SJECCD Employee **2024/2025**

According to our records in Human Resources, you have a child that due to his/her/their birthdate this year may be ineligible for coverage under the District's life insurance policy. This notice does **not** apply to medical, dental, vision, and/or EAP coverage. For your child's life insurance coverage to continue between ages 21 and 23, each year you must submit proof that they continue to be your IRS Dependent and a full time student at an accredited institution. **This is your only notice. Failure to respond will result in your child's termination of life insurance coverage no later than the first of the month after their next birthday. COVERAGE AUTOMATICALLY ENDS THE LAST DAY OF THE MONTH THEY TURN 23.**

To certify your child, between the age of 21 and 23, as still eligible, you must send this completed form along with a copy of their class schedule indicating his/her full time enrollment in an accredited institution. **Your forms are due by the last day of your child's birth month.** If this information is not received timely, his/her/their coverage under the District's life insurance policy(s) will terminate the first of the month following his/her/their birthdate or earlier if it is determined that this dependent has been ineligible. Please contact the Benefits Office in Human Resources for additional details regarding these options, or any other questions you may have.

Please let us know the status of your dependent by completing the appropriate area below: (Please check all applicable items.)

_____ _____
Child's Name *Employee's Name*

____Your records are incorrect. This child's birth date is _____.

____My child is a full-time student at an accredited institution and unmarried, currently enrolled in _____ units. **(Attach proof of student status.)**

Name of school:_____
Please Print

____My child is incapable of self-sustaining employment by reason of physical or mental disability. My child___(is) or ___(is not) covered at this time under Medicare disability program. Please attach a letter from the child's physician explaining the diagnosis, providing relevant ICD9 Codes, extent of disability and prognosis**. *(Please contact the Benefits Office for the proper form for his/her/their physician to complete.)***

____**Student on a medical leave of absence:** If your child is on a school approved, physician-certified medical leave of absence, indicate below the date the leave began, and attach the school & physician certification documentation. *For more information, please call x6713.*

_____
Date Student's Leave Began

____My adult child is no longer eligible. Please terminate coverage.

I certify that the dependent shown above meets all of the requirements for coverage on my account as a full-time student/IRS dependent.

_____ _____
Employee's Signature Date

Please return this form and proof of enrollment to the Benefits Office in Human Resources by the last day of their birth month to avoid your dependent's loss of coverage. If this form is not received timely, your child's coverage will terminate effective the first of the following month. You will receive no other notice. If you have any questions, please call the Benefits Office at 408.223.6713 (x6713).