SURVIVING SPOUSE CONTINUE/DISCONTINUE FORM
CONTRA COSTA COMMUNITY COLLEGE DISTRICT

Retiree/Employee First Name	Retiree/Employee Last Name
Retiree/Employee Last 4 Digits of SSN	**Date of Death**

Surviving Spouse/Dependent First Name	Surviving Spouse/Dependent Last Name	
Surviving Spouse Last 4 Digits of SSN	**Surviving Spouse Birth Date**	**Home or Cell Phone Number**
Address	**City**	**Zip Code**

Please Note: A surviving spouse continues to receive District contributions toward health benefits for a six month period from the date of death of the retiree/employee afterward the surviving spouse may continue but will be required to pay the full premium. Please indicate your intention to continue with District benefits.

Yes	No	Discontinue Coverage
		Delete Coverage Immediately
		Discontinue Coverage After 6 Months From the Date of Death of the Retiree
Yes	**No**	**Continue on CCCCD's Coverage**
		Continue Medical
		Continue Dental
		Continue Vision

Yes	No	Billing
		Bill Quarterly
		Bill Monthly

I certify that the information provided above is accurate and correct.

Signature		Date	

Please return the completed form to Contra Costa Community College District, Human Resources Department

Contra Costa Community College District
500 Court Street, Martinez, California 94553
925.229.1000 www.4cd.edu