

Part Time Faculty Medical Re-Enrollment



I request to continue my enrollment in medical coverage, and I certify the following by checking these boxes:

- ☐ I confirm that an employer other than a California community college district is not paying health insurance premiums for me or my enrolled dependents during the Coverage Period

Fall Coverage Period: November through April
Spring Coverage Period: May through October

- ☐ I understand that as a result of beginning a new eligibility period I may change my medical plan by submitting a completed CalPERS HBD-12 enrollment form
- ☐ I understand that if I wish to waive coverage I must submit a completed CalPERS HBD-12 waiver form

Print Name

Signature

Date

Email your signed and completed form to: benefits@wvm.edu