West Valley - Mission Community College District

HR HUMAN RESOURCES DEPARTMENT

BENEFITS

ASSOCIATE FACULTY HEALTH INSURANCE
MULTI-DISTRICT APPLICATION FOR REIMBURSEMENT
(California Community Colleges Medical Health Insurance Reimbursement Program)

Employee Name: _____ WVMCCD G#: _____

District Email Address: _____ Phone #: _____

Semester Reimbursement Requested: ◯ Fall (Covers the period July – December) ◯ Spring (Covers the period January - June)

Please return to: tracey.frizzell@wvm.edu

NO LATER THAN THE FIRST FRIDAY IN APRIL / FIRST FRIDAY IN NOVEMBER

I certify that the following conditions have been met: (please initial in front of each section)

_____ *Initial here*

1. I currently teach a 40%+ combined load at two or more California community college districts (CCD), including West Valley-Mission CCD ***AND*** I do not teach a 40% or greater load at any single California community college district that offers medical coverage equivalent to that offered to full-time faculty. I currently teach at the following California community colleges districts: *(any assignments paid by the hour **must** be converted into load before entering below)*

CCD 1:	West Valley-Mission CCD	Load:	
CCD 2:		Load:	
CCD 3:		Load:	
CCD 4:		Load:	
CCD 5:		Load:	

_____ *Initial here*

2. No other employer or agency other than a California community college district is paying for my health insurance.

_____ *Initial here*

3. I am currently enrolled as ◯ Employee Only ◯ Employee + 1 ◯ Employee +2 or more

(please complete either 3A or 3B below, do not complete both):

A. in _____ plan through _____
(insert plan/carrier name here) *(insert District name here)*

California Community College. The portion of the premium that I am responsible to pay for this plan during the 6-month coverage period is $_____.
(Fall Semester covers July – December and Spring Semester covers January – June)

OR

B. in _____ plan which I individually purchase and the portion of the
(insert plan/carrier name here)

premium that I am responsible to pay for this plan during the 6-month coverage period is $_____.
(Fall Semester covers July – December and Spring Semester covers January – June)

_____ *Initial here*

4. I understand the following provisions of this program:
   A. I cannot be reimbursed for more than what the allocated benefit is based on the number of dependents on the plan.
   B. I cannot be reimbursed more than once (by WVMCCD programs or alternative programs) for a single cost

C. Reimbursements are made once a semester via direct deposit or check.
   - Direct Deposit – please complete the ACH Authorization Agreement form and return it with your application.
   - Check – will be mailed via U.S. Mail to your home address on file.

D. No applications will be accepted after the submission deadline.

E. The District requires verification of coverage and proof of premium payment for reimbursement.

F. Applications are due the first Friday in November for the Fall Semester and the first Friday in April for the Spring Semester. Verification of load and proof of premium payments are due at least 3 weeks prior to the end of the semester.

_____ *Initial here*

5. I have attached my premium invoice(s) and proof of payment to this application **OR** I confirm that I will submit the premium invoice(s) and proof of payment documents at least 3 weeks prior to the end of the semester.
   - Fall Semester documentation covers the time period of July - December
   - Spring Semester documentation covers the time period of January - June

_____ *Initial here*

6. I have attached proof of load taught at other districts OR I confirm that I will submit the verification of load at least 3 weeks prior to the end of the semester. *(Proof must be submitted on the Associate Faculty Health Insurance Multi-District Load Verification form provided by WVMCCD and each one MUST be signed by an authorized representative from the College to be eligible for consideration. An authorized representative could include Human Resources staff, manager/dean of your department, Office of Instruction staff) Note: This form is not required for WVMCCD load verification. Load for WVMCCD will be verified by HR based on* ***census date*** *data.*

COMMENTS

Employee Signature _____ Date _____

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Please do not submit paper forms; electronic formats only will be accepted as complete

If you submitted this application on time and you later learned that you don't qualify for this program, you may still qualify for Plan #3 WVMCCD Premium Reimbursement Program. Click here for more information/application materials. This application submission date can meet the application submission deadline for Plan #3 and you will then need to submit the Plan #3 application and receipts at least 3 weeks prior to the end of the semester.

ELIGIBILITY VERIFICATION *(To be completed by Human Resources only)*

○ YES. Request for reimbursement is approved. All of the required program criteria have been met and VERIFIED. Required proof of medical plan enrollment, premium payments, and teaching load are attached to this form.

○ NO. Request for reimbursement is denied.
Reason:

Total amount approved: $ _____

Processed and Approved by (HR): _____ Date: _____