

March 2025

***CONTINUING ENROLLEES***  
***IN THE ASSOCIATE FACULTY MEDICAL BENEFITS***  
***PROGRAM***

**Enrollment Period: March 1 - 31, 2025**

You must meet the eligibility criteria listed on the  
“Continuing Enrollees Declaration of Eligibility Form” on page 2 of this  
document and submit the form to Human Resources by  
March 31, 2025 to continue your medical insurance.

**\*\* Please note, if you want to continue your medical insurance,  
you must submit the  
Declaration of Eligibility Form for Continuing Enrollees  
to Human Resources by Monday, March 31, 2025 or your  
medical insurance will end on March 31, 2025.**

As long as you submit the Declaration of Eligibility Form and you’re actively employed and meet the eligibility requirements, the dates of coverage will be April 1, 2025 through September 30 2025. If you resign your position or retire, then your medical insurance ends at the end of the month of your last day on pay.

If you have questions, please contact Christie Colón in the Human Resources Department at 707-527-4304 or [ccolon@santarosa.edu](mailto:ccolon@santarosa.edu).

# DECLARATION OF ELIGIBILITY FORM FOR MEDICAL BENEFITS **FOR CONTINUING ENROLLEES**

SRJC ASSOCIATE FACULTY

Send this form no later than **Monday, March 31, 2025** to:

Human Resources • Santa Rosa Junior College • 1501 Mendocino Avenue • Santa Rosa, CA 95401

OR email [ccolon@santarosa.edu](mailto:ccolon@santarosa.edu)

Employee Name

Employee I.D. Number

**Check the boxes for 1-4 below; fill in the % load in #1 as applicable. Sign and date at the bottom.**

1. TRUE or FALSE I have a cumulative assignment of 40% or greater from all California Community College Districts for which I work. At least 20% of my load is from Santa Rosa Junior College. **List your load from all districts below:**

**Santa Rosa Junior College**

\_\_\_\_\_  
Name of District

\_\_\_\_\_  
Percentage of Assigned Load

\_\_\_\_\_  
Name of other California Community College District\*

\_\_\_\_\_  
Percentage of Assigned Load

\_\_\_\_\_  
Name of other California Community College District\*

\_\_\_\_\_  
Percentage of Assigned Load

**\* If you listed other districts here and you work more than 20% but less than 40% load at SRJC, you must also have those districts complete the "Verification of Teaching Load" form.**

\*\*If you do not have 40% load in Spring 2025, you must work at least 20% load at SRJC and have a cumulative load of 80% for the current semester and past two terms of instruction (Spring 2025 semester, Fall 2024 semester and Summer 2024 term).

Check this box if this applies to you. If this doesn't apply, continue to question 2.

2. TRUE or FALSE No portion of my medical benefits premium is paid by any employer; or by any employer of my spouse or domestic partner; or by any businesses owned by myself, spouse or domestic partner.
3. TRUE or FALSE I do not receive reimbursement for retirement medical benefits or stipends, from any source.
4. TRUE or FALSE I do not receive a payment in lieu of medical benefits from another employer, nor does my spouse or domestic partner from any of their employers.

**NOTE:** Answering FALSE to any of the statements above means you are not eligible for this program.

I understand that the elections I make on the SRJC Associate Faculty Medical Benefits Enrollment Request form will remain in effect for as long as I am eligible to receive the medical benefits offered by Santa Rosa Junior College, or until I make another election during the annual open enrollment period. If I resign my position or retire, then my medical insurance ends at the end of the month of my last day on pay. If I owe a portion of the monthly premium, failure to pay the associate faculty portion of the premium will result in cancellation of my medical plan at the end of the month that I last paid. I understand that I am responsible for reporting any change(s) in the eligibility status of myself, or dependents, within 30 days.

**I hereby declare under penalty of perjury under the laws of the State of California that: the information and documentation I have provided related to this application for medical benefit coverage (including but not limited to this Declaration Form, copies of birth certificates, marriage certificates, domestic partner certificates, verification of teaching load form) are true and accurate to the best of my knowledge.**

I attest by signing below that I have reviewed the information provided on this form and on the supporting documentation and it is to the best of my knowledge and belief true and accurate with no omissions or misstatements.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date