

DECLARATION OF ELIGIBILITY FORM FOR MEDICAL BENEFITS

FOR NEW ENROLLEES

SRJC ASSOCIATE FACULTY

Send this form no later than **Tuesday, March 31, 2026** to:

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

OR email ccolon@santarosa.edu

Employee Name

Employee I.D. Number

Check the boxes for 1-4 below; and 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:**

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](#).**

2. TRUE or FALSE No portion of my medical benefits premium is paid by any other employer; or by any employer of my spouse or domestic partner; or by any businesses owned by myself, spouse or domestic partner other than a California Community College District.
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 made when I initially enrolled 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 owe a premium portion, I agree that my premium payment will be deducted from my paycheck. During a coverage period when I don't receive a paycheck (like summer for instance), I am responsible for making the premium payment directly to the Accounting Department by calling Nicole O'Brien at 707-527-4505. I understand that failure to pay my portion of the premium will result in cancellation of my medical plan at the end of the month that I last paid. If I resign my position or retire, then my medical insurance ends at the end of the month of my last day on pay. 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, and if applicable the 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