DECLARATION OF ELIGIBILITY FORM FOR MEDICAL BENEFITS

FOR NEW ENROLLEES

SRJC ASSOCIATE FACULTY

Send this form no later than Friday, March 29, 2024 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 District*	Percentage of Assigned Load
Name of 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 and you must submit it to SRJC HR by 3/29/2024. Click here for the form.***

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 that I last worked. 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