DECLARATION OF ELIGIBILITY FORM FOR MEDICAL BENEFITS

FOR NEW ENROLLEES

SRJC ADJUNCT FACULTY

Send this form no later than September 30, 2021 at 5 p.m. 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 1-5 below; fill in #2 as applicable. Sign and date at the bottom, to verify that the information you have provided is accurate and correct.

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 your load must be 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, you must also have those districts complete the "Verification of Teaching Load" form and submit it to SRJC Human Resources by September 30, 2021.***

2. TRUE or FALSE I am employed by SRJC as an adjunct faculty member, with a load of 20% or more.
3. 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, including another California Community College District.
4. TRUE or FALSE I do not receive reimbursement for retirement medical benefits or stipends, from any source.
5. 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 his/her 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 Adjunct 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 an open enrollment period. I am enrolling for coverage under the plan option indicated for myself, and those eligible dependents that I have listed, as shown on the Medical Benefits Enrollment Request form. 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