Chabot-Las Positas Community College District

Human Resource Services

Part-Time (ADJUNCT) Medical Benefits

Affidavit for Enrollment and Authorization for Payroll Deductions

TO BE COMPLETED BY PART-TIME (ADJUNCT) FACULTY

I hereby certify under PENALTY OF PERJURY under the laws of the State of California that I do not have access to other medical insurance where all or part of the premium is paid through some other source and that the information I have provided to the District in this Affidavit is true and correct.

Name of Employee (print) _____ W# or SSN _____ Date of Birth _____

Street Address _____ City _____ State _____ Zip Code _____

( ) _____ Email _____

Home Phone

Signature of Employee _____

TO BE COMPLETED BY DIVISION DEAN

Qualifying Semesters & Load: _____ Fall 20___ _____Spring 20___ _____ Summer 20__

Will an assignment be made next semester? ☐ Yes ☐ No Division _____

Name of Dean (Please Print) _____ ( ) _____

Office Phone - Dean

Load Verified by Dean _____ Annual Load:_____

(Signature and Date)

HEALTH PLAN & COVERAGE PERIOD

Name of Medical Insurance Plan: Kaiser Permanente or Anthem Blue Cross

Begin and End Date of Coverage: September 1, 2024 to August 31, 2025

NOTE: Employee is responsible for their share of all monthly payments for medical benefits premiums either by payroll deduction or personal check. Coverage is based on meeting eligibility requirements for the plan year, per 20A.6 of the collective bargaining agreement.