CHABOT-LAS POSITAS COMMUNITY COLLEGE DISTRICT
Office of Human Resources/Benefits Office

MULTIDISTRICT ADJUNCT FACULTY MEDICAL INSURANCE APPLICATION FOR REIMBURSEMENT

Name:_____ W#_____

Academic Year:_____ REIMB. SEMESTER:_____

I certify that the following conditions have been met:

1) The Part-time unit member is currently serving at more than one California community college district, including CLPCCD.
2) The Part-time unit member's total teaching assignments over the last year, at two or more college districts including CLPCCD, is equal to or greater than 40% of full-time teaching assignment. For the purpose of determining eligibility, the last year means the most Fall, Intersession (if applicable), Spring and Summer terms prior to when the unit member starts receiving benefits.
3) They are ineligible to receive health care coverage at a level commensurate with full time faculty in any single district, other than CLPCCD.
4) The Part-time unit member does not receive health from any other employer-sponsored plan, or as covered dependent of anyone receiving coverage from any employer-sponsored plan.
5) The Part-time unit member has purchased a healthcare plan covering themselves and optionally any eligible dependents.
6) Forms must be submitted prior to December 1 for the fall semester and May 1 for the spring semester of the current academic year for reimbursement covering fall and spring semesters.

The required documentation is attached:

1) Proof of medical insurance plan enrollment, premium amount, and payment for medical insurance that was in effect during the applicable semester
2) Proof of teaching load taught at other districts.

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.

Adjunct Faculty Signature:_____ Date:_____

This form and required documentation must be submitted to the Benefits Office, HR Benefits Specialists by email to kvu@clpccd.org or lmacias@clpccd.org no later than December 1 for each Fall semester and May 1 for each Spring semester

ELIGIBILITY VERIFICATION (to be completed by Human Resources Benefits Office only)

☐ APPROVED. Request for reimbursement is approved. Required proof of medical insurance plan enrollment, premium amount and payments, and teaching load are attached to this for.

☐ DENIED. Request for reimbursement is denied for the following reason:

HR Benefits Office Staff Signature:_____ **Date:**_____

Business Services Staff Signature:_____ **Date:**_____

Reimbursement Processed ☐ **Date:**_____

Version Date: July 22, 2026