MULTI-DISTRICT PART-TIME FACULTY HEALTH INSURANCE APPLICATION FOR REIMBURSEMENT

Peralta Community College District

Name:	
PCCD Employee ID:	
Reimbursement Semester:	
Email Address:	
Phone Number:	

I certify that the following conditions have been met:

1. I am currently employed by **two or more California Community College Districts** and my **combined teaching load equals or exceeds 40%**.
2. I **do not teach 40% or more at any single district**.
3. **No other employer or agency** (excluding California community college districts) is contributing to or paying for my health insurance premium.
4. I have completed four (4) Spring and Fall semesters in the immediately preceding four (4) years.
5. Districts can reimburse multidistrict part-time faculty who individually purchase health insurance Benefits, up to a proportionate share of the district's most subscribed family coverage plan as long as you are not eligible for medical coverage at other districts.

Current Teaching Assignments:

Please list all California Community College Districts where you are currently employed and your FTE (Full-Time Equivalent) percentage at each district.

College/District	FTE %

Required Documents:

☐ Screenshot or official document showing your teaching load for <u>each</u> district

☐ If you quality under #5, then please submit an invoice with proof of payment.

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All documents are required. Incomplete submissions will not be processed.

How To Submit Your Application

Submit your completed form **with all required documents**:

- **Email:** Submit your packet via email at benefits@peralta.edu.

Submission Deadlines:

- **Fall semester**: Submit by **November 20**
- **Spring semester**: Submit by **May 20**

No exceptions will be made to the deadlines
Please note that reimbursements will be made via paycheck for part-time faculty enrolled in Peralta's health plans. Reimbursements will be taxable and will be included in your W-2 as taxable.

We encourage you to complete and submit the packet at the beginning of the semester being claimed/applied for and before the dates above.

Employee Certification & Signature:

By signing below, I certify that I meet the eligibility criteria for this reimbursement.
I understand that submission of false or incomplete information may result in denial of reimbursement and/or disciplinary action.

Employee Signature:	
Date:	

Need Help or Have Questions?

For assistance with this form, please contact the Benefits Office:
Email: benefits@peralta.edu
Phone: (510) 466-7229