Peralta Community College
Eligibility Affidavit
50% / 50% and 100% Plan
Fall 2008

RETURN THIS FORM TO THE BENEFITS OFFICE NO LATER THAN MONDAY, SEPTEMBER 15, 2008. INCOMPLETE OR FORMS RECEIVED AFTER THIS DATE WILL NOT BE PROCESSED AND WILL BE RETURNED TO YOU.

Section A: Personal Information

Employee's Name (Last, First, Middle Initial) - please print _____ Social Security Number _____ Date of Birth _____

Street Address - please print _____ City _____ State _____ Zip Code _____

Telephone Number (home) _____ Telephone Number (work) _____ Email Address _____

❑ *Check here if the above reflects any new / updated contact information.*

Section B: Affidavit of Eligibility

Please answer Yes or No to questions 1, 2, and 3. Initial next to your response.

1. Are you currently employed by PCCD as any hourly faculty member? ❑ Yes ❑ No _____ (your initials here)
2. Do you have a fall assignment of 40% or greater? ❑ Yes ❑ No _____ (your initials here)
   (refer to the Instructor Assignment Roster—attach the Instructor Assignment roster to this form)
3. Do you have other access to group medical insurance where all or part of the premium is paid through some source other than personal funds or a Community College District? ❑ Yes ❑ No _____ (your initials here)

Section C: Benefit Options - Circle your Choices and Attach an Adjunct Universal Enrollment Form.

Coverage 50% / 50% Plan	Your 50% / 50% Monthly Share Employee pays 3 months, PCCD pays 3 months Kaiser	Your 50% /50% Monthly Share Employee pays 3 months, PCCD pays 3 months CoreSource
Single	$223.00	$262.54
Two Party	$446.01	$586.59
Three Party	$631.10	$881.25

Coverage 100% Plan	Your 100% Monthly Share Employee makes 3 installments for 6 months of coverage Kaiser	Your 100% Monthly Share Employee makes 3 installments for 6 months of coverage CoreSource
Single	$446.01	$525.09
Two Party	$892.02	$1,173.19
Three Party	$1,262.20	$1,762.51

Coverage Employee makes 3 installments for 6 months of coverage	Delta Dental PPO Dental Plan You pay full monthly premium	United HealthCare DMO Dental Plan You pay full monthly premium
Single	$60.67	$23.84
Two Party	$103.14	$38.15
Three Party	$157.75	$58.41

I understand that if I waive coverage or do not enroll in coverage, I can enroll at a later date if there is a QUALIFYING EVENT as permitted and defined by HIPAA governances.

Section D: Payroll Deduction Authorization

50% / 50% Plan: I hereby authorize Peralta Community College District Payroll Department to deduct the **above-referenced CIRCLED** amounts from my monthly paycheck to pay for 50% of the medical premium cost and 100% of the dental premiums for the amount of coverage I have selected. Deductions will occur for the 3 pay periods October, November and December 2008.

_____ **(please sign and date)**

OR

100% Plan: I hereby authorize Peralta Community College District Payroll Department to deduct the **above-referenced CIRCLED** amounts from my monthly paycheck to pay for 100% of the medical and or dental premium cost for the amount of coverage I have selected. Deductions will occur for the 3 pay periods October, November and December 2008. I do not qualify for the District contribution and agree to pay 100% of the above-referenced circled premium. _____ **(please sign and date)**

Section E: Complete and Attach Required Forms: Adjunct Faculty Benefit Checklist & Universal Enrollment Form Checklist are attached to this Affidavit. _____ (initial here)