

**Peralta Community College  
Eligibility Affidavit  
50% / 50% and 100% Plan  
Spring 2009**

**RETURN THIS FORM TO THE BENEFITS OFFICE NO LATER THAN MONDAY, FEBRUARY 9, 2009. 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
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 Benefit Enrollment Form.**

Coverage 50% / 50% Plan	Your 50% / 50% Monthly Share: 6 months of coverage paid in 3 in- stallments  <b>Kaiser</b> Monthly Rate/Payroll Rate	Your 50% / 50% Monthly Share: 6 months of coverage paid in 3 installments  <b>CoreSource</b> Monthly Rate/Payroll Rate	Coverage 100% Plan	Your 100% Monthly Share: 6 months of cover- age paid in 3 installments  <b>Kaiser</b> Monthly Rate/Payroll Rate	Your 100% Monthly Share: 6 months of cover- age paid in 3 installments  <b>CoreSource</b> Monthly Rate/Payroll Rate
Single	\$223.00/mo; 446.00/pr	\$262.54/mo; 525.08/pr	Single	446.01/mo; 892.02/pr	525.09/mo; 1050.18/pr
Two Party	\$446.01/mo; 892.02/pr	\$586.59/mo; 1173.18/pr	Two Party	892.02/mo; 1784.04/pr	1173.19/mo; 2346.38/pr
Three Party	\$631.10/mo; 1262.20/pr	\$881.25/mo; 1762.50/pr	Three Party	1262.20/mo; 2524.40/pr	1762.51/mo; 3525.02/pr

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 March, April & May 2009.

\_\_\_\_\_ (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 March, April and May 2009. 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)