FORM HI1

NORTH ORANGE COUNTY COMMUNITY COLLEGE DISTRICT

ADJUNCT FACULTY HEALTH INSURANCE PREMUIM REIMBURSEMENT – PART 1

Employee Name:_____ **Banner ID or Soc Sec #**_____
Last First MI

Home address: _____

If address does not match District records, do we have your approval to change our records? ____Yes ____No

Daytime Phone # _____ Please check term you are applying for:

_____ 2015 Fall Trimester/Semester

_____ 2016 Winter Trimester

_____ 2016 Spring Trimester/Semester

I. CURRENT TERM ASSIGNMENT(S)

Location of current assignment (check all that apply):	[ ] CYPRESS	[ ] FULLERTON	[ ] SCE
Indicate the percentage of assignment and type of assignment at each location:	Assignment %____ [ ] Instructor [ ] Counselor [ ] Librarian	Assignment %____ [ ] Instructor [ ] Counselor [ ] Librarian	Assignment %____ [ ] Instructor [ ] Counselor [ ] Librarian

II. PREVIOUS TERM ASSIGNMENT(S)

Check all semesters for which you performed assignments as an adjunct faculty member at Cypress College and/or Fullerton College.					Check all trimesters for which you performed assignments as an adjunct faculty member with the School of Continuing Education(SCE)								
Spring 2015 SEM	Fall 2014 SEM	Spring 2014 SEM	Fall 2013 SEM	Spring 2013 SEM	2015 Spring TRI	2015 Winter TRI	2015 Fall TRI	2014 Spring TRI	2014 Winter TRI	2014 Fall TRI	2013 Spring TRI	2013 Winter TRI	2013 Fall TRI

III. HEALTH CARE COVERAGE

Are you eligible for or enrolled in health care coverage sponsored or paid, in full or in part, by another employer? [ ] YES [ ] NO

Are you eligible for or enrolled in health care coverage sponsored or paid, in full or in part, by the employer of your spouse, domestic partner, or other person? [ ] YES [ ] NO

IV. CERTIFICATION

- I have read the requirements for eligibility as provided in Article 12 of the collective bargaining agreement between Adjunct Faculty United and the District and Certify that I am eligible to participate in the Health Insurance Premium Reimbursement Program.
- I hereby certify that I am not otherwise eligible for or enrolled in health care coverage, as an employee, spouse, domestic partner, or dependent, under a health insurance program sponsored or paid, in full or in part, by another employer.
- In making this application for health insurance premium reimbursement, I agree to provide the District with such information as is reasonably necessary to validate my eligibility. I further authorize the District to request from my insurance carrier such information as may be reasonably necessary to validate my eligibility.
- I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct to the best of my belief and knowledge. I understand that falsification regarding this application will result in immediate termination of the District contribution and will render me ineligible for further participation in the program.

Employee Signature_____ **Date**_____

FORM HI2

NORTH ORANGE COUNTY COMMUNITY COLLEGE DISTRICT

ADJUNCT FACULTY HEALTH INSURANCE PREMUIM REIMBURSEMENT – PART II

Employee Name:_____ **Banner ID or Soc Sec #**_____
Last First MI

I. NOTICE TO EMPLOYEE

- The Health Insurance Premium Reimbursement Program is intended to assist you with the premium cost for an independent health care plan in which you are enrolled. If you meet the eligibility requirements, you may be reimbursed for the actual amount of insurance premiums paid by you to an independent health care plan in which you are enrolled, up to a maximum of $870 per regular semester, or $580 per regular trimester.

- **If you qualify for reimbursement, payment will be made directly to you in a single payment, by separate reimbursement check payable to you.** You may elect to take personal delivery of the premium reimbursement check directly from the District Benefits Office, or have the check mailed to you. If you select the mailing option, it is with the understanding that the District will remit the check via regular U.S. mail to the address you specify. You further understand and agree that the District will not be responsible in the event of untimely delivery, non-delivery, or loss of checks by the post office.

  Check one Box Only:

  [ ] I will take personal delivery of checks from the District Benefits Office.

  [ ] I request that the District Benefits Office mail Checks to me at (specify address):

  _____

- The District may request from you and your insurance carrier such information as is necessary to validate your eligibility, proof of insurance, and proof of payment including, but no limited to, invoices or billing notices, canceled checks, etc. Failure to provide information requested by the District to validate your application for reimbursement, within 21 days of the request, will render you ineligible for reimbursement.

- Federal and State withholding taxes will not be deducted from your reimbursement check. You are responsible for any federal or state tax liability arising out of, or related to, the receipt of reimbursement from the District for medical insurance premiums, and you agree to hold the District harmless with respect thereto.

- **Irrespective of your participation in the Health Insurance Premium Reimbursement Program, you are financially responsible for ensuring the payment of premiums to your health insurance carrier. The District will not be responsible in the event your coverage lapses or is canceled due to nonpayment of premiums. The District will not be held responsible for conditions imposed by regulatory agencies or insurance carriers that are beyond the control of the District.**

II. HEALTH INSURANCE PLAN INFORMATION (To Be Completed By Employee)

Name of Health Insurance Plan:_____ Beginning Date of Coverage:_____

Mailing Address of Health Insurance Plan:_____

Premium Billing Period: [ ] Monthly [ ] Quarterly [ ] Semi-Annually [ ] Other _____

Amount of Premium Each Billing Period:_____ Premium Due Date:_____

Does premium amount above include coverage for spouse and/or dependents? [ ] YES [ ] NO

If premium amount includes coverage for spouse and/or dependents, specify amount for your coverage only: $_____

III. EMPLOYEE CERTIFICATION

I have read and understand the terms and conditions as set forth herein. I declare under penalty of perjury under the laws of the State of California that the information provided by me herein is true and correct to the best of my belief and knowledge. I understand that falsification regarding this application will result in immediate termination of the District contribution and will render me ineligible for further participation in the plan.

Employee Signature: _____ **Date:**_____