MULTIDISTRICT PART-TIME FACULTY HEALTH INSURANCE
APPLICATION FOR REIMBURSEMENT

|  |  |
| --- | --- |
| Reimbursement Semester Requested: |  |

I certify that the following conditions have been met: *[Include all district conditions here]*

1. I currently teach a 40% combined load at two or more districts.

|  |  |
| --- | --- |
| I currently teach at the following districts (Please list all districts): |  |

1. No other employer or agency other than a community college district is paying for my health insurance.

I understand the following provisions of this program: *[Include district provisions specific to your program here. The items listed below are only examples of possible language and can be deleted or modified to fit your district.]*

1. The $XX maximum reimbursement per semester will be paid to me; it will not be forwarded to any insurance carrier or other 3rd party.
2. Reimbursements are made *[insert district policy here]*
3. No additional reimbursements are available when the semester’s allotment has been exhausted.
4. Reimbursements will be issued approximately XX to XX days after all documentation has been received and approved by the district.
5. The district may request verification of coverage.
6. Applications must be submitted prior to *[insert date]* of the current academic year for reimbursements covering Fall and Spring semesters.

I have attached my premium invoice(s) and proof of payment to this form for health insurance coverage that was in effect during the applicable semester.

I have attached proof of load taught at other districts. *[This can be modified to list specific types of proof requested. ]*

Please complete the section below:

|  |  |
| --- | --- |
| Signature: |  |
| Date: |  |
| Name: |  |
| Address: |  |
| Phone: |  |

**ELIGIBILITY VERIFICATION (To be completed by Human Resources only)**

|  |  |
| --- | --- |
| **Mark Your Selection with X** | **Choose one:**  |
|  | YES. Request for reimbursement is approved. All of the required program criteria have been met and VERIFIED. Required proof of medical plan enrollment, premium payments, and teaching load are attached to this form. |
|  | NO. Request for reimbursement is denied. If no, reason for denial: |
| Total amount approved: | $ |
| Date submitted to Payroll: |  |
| HR Staff Member Review: |  |
| Date: |  |
| HR Manager Approved: |  |
| Date: |  |

**District Instructions:** (Delete these instructions before using this form.)

1. This is a sample form that should be modified to fit the specific program at each district. The district can include any additional conditions that apply to their program. Districts should modify or delete the example provisions listed and add any additional provisions that apply to their program.
2. The instructions in *blue italics and brackets* within the document should be deleted once the district has customized the form.