DUE IN BY HR 9/16/2024

san josé·evergreen COMMUNITY COLLEGE DISTRICT

HUMAN RESOURCES SERVICES GROUP

▪ Forty South Market Street ▪ San José, CA 95113 408-223-6713 ▪ 408-239-8804 (fax)

Associate Faculty – Kaiser Permanente Plan

Verification of Eligibility Form

Fall 2024 Coverage Period: 09/01/2024 – 02/28/2025

Required:

Name:_____ (Print)

Employee Number: _____ **Phone Number**: _____

Campus: _____**EVC** _____**SJCC** **Division**: _____

I ELECT TO ENROLL IN OR CONTINUE THE FOLLOWING PLAN (please check ONE box):

	Employee Only	Employee + Spouse	Employee + Domestic Partner	Employee + Child/Children	Family
TRADITIONAL PLAN (PLAN A)	☐	☐	☐	☐	☐
	Employee Only	Employee + Spouse	Employee + Domestic Partner	Employee + Child/Children	Family
DEDUCTIBLE PLAN (PLAN B)	☐	☐	☐	☐	☐

☐ **This is a NEW enrollment.** I was **not** enrolled in a District Plan spring '24. (*Plan A or Plan B enrollment form is also required)*

☐ **I wish to CONTINUE my current district coverage in fall 2024 I had in spring '24,** (no changes. *(This form is due.)*

☐ **I wish to SWITCH my district coverage from Plan A to Plan B, or Plan B to Plan A.** (The new plan enrollment form is also required.)

☐ **I wish to change my current coverage and ADD/REMOVE a dependent(s) effective 09/01/2024.** (Proof of eligibility and a Member Change Form are required)

☐ **I was enrolled spring 2024 but will not qualify OR wish to CANCEL my coverage effective 09/01/2024** *(This signed form is due.)*

I attest by my signature below that I meet the following eligibility criteria listed and agree to the following:

a) I meet the eligibility for coverage criteria under Article 9.2.3 of the AFT Collective Bargaining Unit;
b) I do no/will not have any other coverage, **nor** will my dependents (if enrolling/enrolled);
c) I agree to have 50% of the premium for any eligible dependent I enroll deducted from my paychecks accordingly.

I authorize payroll to deduct the dependent portion of the plan premium from my paychecks this semester.

Signed: _____ **Date:** _____

For HR Only: Eligibility Verified: _____ Processed SISC ☐ Benetrac ☐ Colleague ☐

If you do not submit this form to HR by the due date (and any other required documentation) your coverage will terminate/you will not be eligible for coverage as of 9/1/2024. NO EXCEPTIONS Rev 08/24