MULTIDISTRICT PART-TIME PART TIME HEALTH INSURANCE APPLICATION FOR REIMBURSEMENT

Effective with the Fall 2023 semester, qualifying multi-district part-time Part-Time are eligible to participate in the Multi-District Part- Time Part-Time Health Insurance Reimbursement Program.

Documentation Requirements:

The Unit Member must submit the **Multidistrict Part-Time Unit Member Reimbursement application (Form 3)** and provide documentation that the cumulative teaching assignment is equal to or greater than 40% such as:

1. Image of the online class schedule from the applicable community college/district website.

    a. The image must include the multi-district Part-Time member's name, community college name, number of units, and term. **OR**

    b. Signed employment agreement. The contract or agreement must include the multi-district Part-Time member's name, community college name, number of units, and term.

2. Proof of enrollment in a health insurance plan and the amount of the monthly premium.

Please submit application and documentation to the Human Resources Benefits Department located at

900 Otay Lakes Road, Chula Vista CA ,91910 -Room# 46C-103 or via email at SWCbenefits@swccd.edu.

If you have any questions, please contact the Benefits office at (619)421-6700 ext. 5260.

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APPLICATION FOR REIMBURSEMENT (FORM 2)

Full Name:	
Staff ID:	
Email:	

Semester in which reimbursement is being applied:	

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

Medical Health Insurance Provider:	
Monthly Out of pocket Premium:	

Please list the current District you are working in and the FTE percent below:

FTE at San Diego Community College District	
FTE at Grossmont-Cuyamaca CC District	
FTE at Southwestern Community College District	
FTE at	
FTE at	
FTE at	

Total FTE:	

I understand the following provisions of this program:

1. The maximum reimbursement per semester will be paid to me; it will not be forwarded to any insurance carrier or other third party.

2. Request for Reimbursement must be submitted one month prior to the end of the Spring Semester in each academic year.

3. No additional reimbursements are available when the semester's allotment has been exhausted.

4. Reimbursements will be processed approximately **30** days after all documentation has been received and approved by the District's Human Resources Benefits Department.

By signing below, I certify all information is true and in compliance with the above requirements.

Signature: Date:

ELIGIBILITY VERIFICATION (To be completed by Human Resources- Benefits Department only)

Mark Your Selection with X	Choose one:
	YES. Request for reimbursement is approved. All 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 Benefits Department: ______

HR Benefits Specialist Review and approval: ______

Date: ______