



HUMAN RESOURCES  
1501 Mendocino Avenue  
Santa Rosa, California 95401  
(707) 524-1624  
FAX (707) 527-4967

August 29, 2008

**ANNOUNCEMENT TO ALL ADJUNCT FACULTY MEMBERS**  
**Enrollment Period October 1, 2008 through March 31, 2009**

You may be eligible for a partial payment of a health benefit premium for yourself, your spouse or registered domestic partner, and dependent children. This program is part of the benefit package between the District and the All Faculty Association and may be subject to change and/or cancellation after **June 30, 2009**.

The enclosed materials are provided for you to determine your eligibility to receive the benefit. Please read the enclosed materials carefully:

**Summary of Benefits & Eligibility Requirements**  
**Declaration of Eligibility**  
**Health Benefits Enrollment Request**  
**Delinquent Payment Policy**

Whether you wish to enroll for the first time or continue your existing coverage, ***you must enroll or re-enroll by September 30, 2008***. All eligibility requirements must be met without exception, and all forms must be fully completed and returned according to the instructions.

**If you are enrolling in the program for the first time:**

- You must meet the eligibility criteria as listed on the Declaration of Eligibility Form,
- You must provide a marriage certificate, domestic partner affidavit and birth certificates for all eligible dependents.

**If you are continuing in the program:**

- You must meet the eligibility criteria as listed on the Declaration of Eligibility Form,
- You must provide a copy of your most recent signed IRS Form 1040 as a verification of dependent eligibility.
- If your dependent is a full-time student, a copy of student enrollment verification is required.

**You may be eligible to participate in the IRC-125 Plan if:**

- You meet the eligibility criteria as stated on the Declaration of Eligibility Form (**for more information, see Payroll's flyer attached**).

The District will no longer provide a 100% reimbursement to employees (employee and spouse or employee and domestic partner) who both meet the eligibility criteria to participate in the adjunct health program. You must now enroll in either double or family coverage and are responsible to pay the 50% premium.

If you meet the eligibility requirements, as described in the "Summary of Benefits & Eligibility Requirements", please complete the "Declaration of Eligibility", "Enrollment Request", "Delinquent Payment Policy", and mail these forms to Human Resources postmarked no later than September 30, 2008. You may also deliver your forms to the Human Resources mailbox in Bailey Hall, Santa Rosa Campus, by 5:00 P.M., on Tuesday, September 30, 2008. You will be notified in writing of your benefit status.

If you have questions, please call the Human Resources Department at 524-1624, leave a message and your call will be returned in a timely manner.

# SRJC ADJUNCT FACULTY: DECLARATION OF ELIGIBILITY

**MAIL Declaration of Eligibility with the Enrollment Request, postmarked no later than September 30, 2008 to:**  
*Human Resources • Santa Rosa Junior College • 1501 Mendocino Avenue • Santa Rosa, CA 95401*  
**OR RETURN to Human Resources mailbox in Bailey Hall by 5:00 p.m., September 30, 2008.**

\_\_\_\_\_  
Employee's Legibly Printed Name

\_\_\_\_\_  
Social Security Number

*Circle your responses to 1-7 below; fill in # 4 as applicable. Sign and date at the bottom, to verify that the information you have provided is accurate and correct.*

1. TRUE or FALSE For Adjunct faculty with a date of hire BEFORE July 1, 2008, ONLY: I have been employed as an adjunct faculty member at SRJC for two of the past three terms (Spring 2008 semester, Summer 2008 term, Fall 2008 semester).
2. TRUE or FALSE For Adjunct faculty with a date of hire AFTER July 1, 2008, ONLY: I have performed my adjunct faculty job for five semesters since my most recent date of hire at SRJC.
3. TRUE or FALSE I am currently employed by SRJC as an adjunct faculty member, with a load of 20% or more.
4. TRUE or FALSE I currently have a cumulative assignment of 40% or greater from all Community College Districts for which I work.

List the districts from which your current cumulative assignment load is received:

_____ Santa Rosa Junior College Name of District	_____ Percentage of Assigned Load
_____ Name of District	_____ Percentage of Assigned Load
_____ Name of District	_____ Percentage of Assigned Load

5. TRUE or FALSE No portion of my health benefits premium is paid by any employer, or by any employer of my spouse or domestic partner, including any businesses owned by myself, spouse or domestic partner, including another Community College District.
6. TRUE or FALSE I do not receive Medicare benefits, or retirement medical benefits or stipends, from any source.
7. TRUE or FALSE I do not receive a payment in lieu of medical benefits from another employer, nor do my spouse or domestic partner from any of their employers.

**NOTE:** Answering FALSE to any of the statements above means you are not eligible for this program.

I understand that the elections I make on the SRJC Adjunct Faculty Health Benefits Enrollment Request form will remain in effect for as long as I am **eligible** to receive the health benefits offered by Santa Rosa Junior College, or until I make another election during an open enrollment period. I am enrolling for coverage under the plan option indicated for myself, and those eligible dependents that I have listed, as shown on the Health Benefits Enrollment Request form. I understand that I am responsible for reporting any change(s) in the eligibility status of myself, or dependents, within 30 days.

**I hereby declare under penalty of perjury under the laws of the State of California that: the information and documentation I have provided related to this application for health benefit coverage (including but not limited to this Declaration Form, copies of birth certificates, marriage certificates, domestic partner certificates, school enrollment forms and IRS Form 1040) are true and accurate to the best of my knowledge.**

I attest by signing below that I have reviewed the information provided on this form and on the supporting documentation and it is to the best of my knowledge and belief true and accurate with no omissions or misstatements.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**SRJC ADJUNCT FACULTY  
Health Benefits Enrollment Request**

**MAIL Enrollment Request with the Declaration of Eligibility postmarked no later than September 30, 2008 to:  
*Human Resources • Santa Rosa Junior College • 1501 Mendocino Avenue • Santa Rosa, CA 95401*  
**OR RETURN to Human Resources mailbox in Bailey Hall by 5:00 p.m., September 30, 2008.****

Employee's Printed Name	Social Security Number *	Date of Birth *	
Street Address	City	State	Zip Code
Home Phone	Work Phone	E-mail address	

**\*\*\* Please list the names of those eligible family members to be covered under your health plan choice. You must provide a copy of your most recent signed IRS Form 1040 to verify dependent eligibility.**

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**Choose ONE of the TWO options explained below, place a check mark in front of the level of coverage you wish to select, and sign the form prior to returning it. These are the only options available to faculty, regular and adjunct.**

**Note:** Because these are SRJC group plans, you will not be excluded from joining either plan for pre-existing conditions.

1.  I select the Kaiser Permanente SRJC Group Health Plan, and I agree to pay the adjunct faculty 50% portion of the premium cost on a monthly basis for the period of October 2008 through March 2009.

**Check the coverage requested:**

<input type="checkbox"/> Single:	100% premium = \$ 322.85	Adjunct faculty 50% portion = \$ 161.43
<input type="checkbox"/> Double:	100% premium = \$ 694.13	Adjunct faculty 50% portion = \$ 347.07
<input type="checkbox"/> Family:	100% premium = \$ 952.41	Adjunct faculty 50% portion = \$ 476.21

2.  I select the SISC Blue Shield SRJC Group Health Plan, and I agree to pay the adjunct faculty 50% portion of the premium cost on a monthly basis for the period of October 2008 through March 2009.

**Check the coverage requested:**

<input type="checkbox"/> Single:	100% premium = \$ 551.00	Adjunct faculty 50% portion = \$ 275.50
<input type="checkbox"/> Double:	100% premium = \$ 1,185.00	Adjunct faculty 50% portion = \$ 592.50
<input type="checkbox"/> Family:	100% premium = \$ 1,628.00	Adjunct faculty 50% portion = \$ 814.00

**I understand that the dependents that are being enrolled meet SRJC dependent guidelines. A copy of your most recent signed IRS Form 1040 is required as verification of dependent eligibility.**

\_\_\_\_\_  
Signed under penalty of perjury under the laws of the State California. \_\_\_\_\_ Date

\*All information will be used exclusively by SRJC to administer the program and will not be disclosed unless required by law.

**SRJC ADJUNCT FACULTY HEALTH BENEFITS**  
***SUMMARY OF BENEFITS & ELIGIBILITY REQUIREMENTS***

**Initial Eligibility Requirements**

1. For Adjunct faculty with a date of hire BEFORE July 1, 2008, ONLY: Must have taught at SRJC for two of the past three semesters.
2. For Adjunct faculty with a date of hire AFTER July 1, 2008, ONLY: Must have performed your adjunct faculty job for five semesters since your most recent date of hire.
3. Must be a current SRJC adjunct faculty member with a load of 20% or more.
4. Must have a current cumulative load of 40% or greater from all community college districts.
5. Must not have any portion of your medical benefits premium paid by another employer, or by any employer of your spouse or domestic partner, including any businesses owned by your self, spouse or domestic partner including another Community College District.
6. Must not receive Medicare benefits, or retirement medical benefits or stipends, from any source.
7. Must not receive a payment in lieu of medical benefits from another employer, nor from any employer of your spouse or domestic partner.

**Continuing Eligibility Requirements**

1. Must meet eligibility requirements 1 through 7 as described above.
2. If you do not meet eligibility requirement #4, you must have a cumulative load, from all Community College sources, of 80% for the current and past two terms of instruction (Spring 2008 semester, Summer 2008 term, Fall 2008 semester)
3. You must provide a signed copy of your most recent IRS Form 1040 to verify dependent eligibility.
4. If a plan provider requires additional verification data, you will be notified about what is needed and where to submit it.

**Plan Selection**

There are two health insurance options available for all faculty, regular and adjunct.  
You may choose ONLY ONE of the two options:

Option #1: Kaiser Permanente SRJC Group Plan

Option #2: Blue Shield SRJC Group Plan

**Plan Payment**

- The individual adjunct faculty member is responsible to make a monthly payment in the amount of 50% of the premium.
- NEW: Starting October 2008, your 50% premium payment will be deducted from your paycheck. During a coverage period when you do not receive a paycheck, the District will provide payment vouchers/invoices to submit along with your 50% payment (i.e. summer if you do not teach a summer course).
- Failure to pay the adjunct faculty portion of the premium will result in cancellation of this benefit (see attached payment policy).

**Dates of Enrollment**

The current enrollment period is from September 1, 2008 through September 30, 2008. When “current enrollment period” is used in the attached documents, it means September 1, 2008 through September 30, 2008.

**Dates of Coverage**

The dates of coverage for employees who meet the eligibility criteria during the current enrollment period are October 1, 2008 through March 31, 2009.

## **Adjunct Health Premium Delinquent Payment Policy**

Effective October 1, 2008, you are required to participate in the IRC-125 Plan. Your monthly premium payments will be deducted from your monthly paychecks; however, you are responsible for premium payments in any month that you do not receive a paycheck. For example, if you do not teach summer school, you are responsible for the 50% premium payment for the months of July and August. These payments are due by the 15<sup>th</sup> of each month for the current month.

When a payment is not received within 30 days of the due date, a courtesy call will be made to the employee informing them of the amount past due and that failure to pay may result in a loss of coverage. If the payment is not received within 60 days of the original due date, a notice will be sent (certified, return receipt) informing the employee that they will be dropped from the benefit program.

If you are dropped for delinquent payment, you will not be eligible to participate again in the adjunct health benefit program until the account is brought current. If the delinquency is paid off, you will be eligible for enrollment at the next regular enrollment period.

### **EXAMPLE**

7/15/08	Payment due
8/15/08	A courtesy call will be made indicating payment must be received by 9/30/08 -
9/15/08	Final notice sent indicating payment must be received by 9/30/08
9/30/08	Employee is dropped from the coverage

***Please sign below indicating that you have read and understand this policy:***

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date