



Reimbursement Request

Multi-District Part-Time Faculty Health Insurance Program

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

To be eligible for reimbursement of a portion of your paid medical health insurance premium, a San Diego Community College District adjunct faculty must meet all of the following criteria:

1. Adjunct faculty member is not eligible to receive the full District contribution in the SDCCD medical plan.
2. Adjunct faculty member does not qualify for benefits at another California community college district which offers part-time faculty benefits.
3. Health insurance premiums for adjunct faculty members or their dependents are not paid by an employer other than a California community college district.
4. Adjunct faculty member has a combined teaching assignment equal to or greater than .4 FTE at two or more California community college districts.

First Name	Last Name
Employee ID	Email
Medical Health Insurance Provider	Monthly Out of Pocket Premium Cost
FTE at San Diego Community College District	
FTE at Grossmont-Cuyamaca CC District	
FTE at Palomar Community College District	
FTE at Mira Costa Community College District	
FTE at Southwestern Community College District	
FTE at _____ (write in)	
FTE at _____ (write in)	
Total FTE	

The following required documentation is due once per semester.

1. Provide documentation to verify that the multi-district part-time faculty member's teaching assignment is equal to or greater than .40 FTE (40% of a full-time assignment). Documentation includes:
 - o Image of the of the online class schedule from the applicable community college/district website. The image must include the multi-district part-time faculty member's name, community college name, number of units, and term.
 - o Signed FTE contract or agreement. The contract or agreement must include the multi-district part-time faculty member's name, college name, number of units, and term.
2. Provide documentation to verify enrollment in a health insurance plan and the amount of the premium.
 - o For the spring semester, provide January through June premium bills.
 - o For the fall semester, provide July through December premium bills.

To request reimbursement, I understand that I must submit this reimbursement request form and required documentation *each and every* semester by the deadline:

- o Spring semester due by July 1 for August 10 reimbursement
- o Fall semester due by January 2 for February 10 reimbursement

By signing below, I acknowledge and agree to the above requirements.

Name	Signature	Date
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