West Valley - Mission Community College District

HR HUMAN RESOURCES DEPARTMENT

BENEFITS

ASSOCIATE FACULTY BENEFITS REIMBURSEMENT PROGRAM APPLICATION
(See reverse side of this form for program requirements)

EMPLOYEE NAME:_____Last 4 of SSN#_____

ADDRESS:_____CITY_____ZIP_____

HOME TELEPHONE: (___)_____E MAIL ADDRESS:_____

COLLEGE:_____EXT:_____DEPARTMENT:_____

I wish to participate in the Associate Faculty Benefits Reimbursement Program for my insurance premium costs. I have met the following eligibility requirements:

_____ 1. having re-employment preference, maintaining a .067 load per semester and remaining in re-employment preference status; or

2. having at least a 40% load if I meet one of the following qualifications:

_____ a. Associate members who have a load with the West Valley-Mission Community College District of at least 40% for three consecutive semesters are eligible for one of the programs beginning in the third semester.

_____ b. Subsequent to earning eligibility, if the member's assignment falls below 40%, but is at least 20%, the member shall retain eligibility. If a member's assignment falls below 40% for a second consecutive semester, the member shall lose eligibility and must reestablish eligibility by meeting the original requirement for eligibility.

I am currently enrolled in the following medical, prescription, dental, vision plan(s):

_____

Policy Number(s) _____Date First enrolled_____

Premium cost: $_____$_____$_____
per (check one): _____month_____quarter _____year

This premium cost represents premium for myself only*: [ ] Y [ ] N

***if the premium you pay includes coverage for other family members (spouse, children), you will need to provide a breakdown that shows whiat portion of the premium is for yourself only.*

Employee Signature:_____Date:_____

Please return this application to Tracey Frizzell in Human Resources by the first Friday in November for the Fall Semester and by the First Friday in April for the Spring Semester. *Proof of insurance payment must be submitted* at least three weeks prior to the end of the semester. Forms can be mailed, emailed to tracey.frizzell@wvm.edu or faxed to (408)867-9059.

Rev. 3/14/16

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ASSOCIATE FACULTY BENEFITS INFORMATION

A fund of $60,000 per fiscal year has been established to fund Associate Faculty benefits. The money shall be divided evenly between the two halves of the year (January – June, July – December). Associate Faculty members are eligible for medical, dental, vision, and prescription benefit premium reimbursement if they meet the following qualifications:

- must have re-employment preference with West Valley-Mission Community College District, maintaining a .067 load per semester and remaining in re-employment preference status; or
- must currently have at least 40% assignment & also have at least 40% assignment in the previous two consecutive semesters for West Valley-Mission Community College District.
- must be currently assigned at least 40% faculty assignment for West Valley-Mission Community College District. Members who have previously earned eligibility by being assigned at least a 40% faculty assignment for the prior three semesters may fall below meeting the 40% requirement for one semester and remain eligible for reimbursement as long as the member has at least a 20% assignment for that semester. If the member remains below 40% for a second consecutive semester the member will lose eligibility and must reestablish eligibility by meeting the original requirements for eligibility.
- must be enrolled in a Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), or other insurance health plan of choice that is licensed and registered by either the California Department of Insurance (DOI) or by the California Department of Managed Health Care (DMHC), during the Fall Semester Period (July – December) or the Spring Semester Period (January – June).
- **a completed Request Form must be submitted to Tracey Frizzell in Human Resources by the first Friday in November for the Fall semester and by the first Friday in April for the Spring semester.**
- **proof of medical, dental, vision, and/or prescription plan enrollment, along with all cancelled checks, cash receipts, money order receipts, or credit card receipts as proof of payment must be submitted at least three weeks prior to the end of the semester.**
- a new Request Form & documentation of coverage must be submitted for each semester of enrollment in this Reimbursement Program.
- at the end of each semester, each eligible member will receive a payment of either 1) the amount of premium representing six months of coverage or 2) $1,000, whichever is less. If the amount available for reimbursement of paid premiums ($30,000 per six months) is not sufficient to meet all the submitted claims, each eligible claimant shall receive an equal prorated share of the $30,000.
- **Failure to submit the required proof of enrollment/and or proof of payment will result in employee ineligibility for participation in this Reimbursement Program.**

If you have questions regarding this program, please contact Tracey Frizzell at (408) 741-2168.