



Los Angeles Community College District Part-Time Faculty Health Benefits Program

Premium Only Plan (POP)

Complete, sign, and send to:

LACCD Health Benefits Call Center
770 Wilshire Boulevard
Los Angeles, CA 90017

Spring 2010
Semester/Year

Name _____

Address _____

City _____

State _____ Zip _____

All employees MUST provide an e-mail address:

Proof of Eligibility

True or False (*Check mark as applicable*)

- Currently (or may be) employed as a part-time faculty member with a .33 FTE or higher teaching load next semester
- Have taught 3 or more spring/fall semesters out of the previous 8 consecutive semesters with at least a .33 FTE work load with LACCD
- Currently or will be eligible for hospital/medical coverage through another employer (i.e., through a spouse's employer, another job, etc.)

Affidavit & Salary Reduction Agreement

I understand that my participation in the LACCD health insurance plans is contingent upon verification of my initial and continued eligibility and that my required premium payments will be deducted from my salary warrants. I authorize LACCD to reduce my regular gross salary by the pro-rated premium amount due each month. I understand that this salary reduction shall be limited to ten monthly pay periods representing twelve months of coverage. Should my eligibility for this benefit end, or my premium payments exceed my net take-home pay in any month, I understand that my participation in the health insurance plans will terminate. In addition, I understand I may become ineligible to re-enroll in the health insurance plans until the start of the next annual cycle. Lastly, I understand that I must remain in the health insurance plans for the entire plan year if I continue to be eligible for participation.

I hereby affirm, under penalty of perjury, that the information I have provided in this application is true and correct to the best of my knowledge and that I have read and understood the above.

Signature _____

Date _____

Note: if your assignment changes, making you ineligible for the Premium Only Plan, you may be eligible for COBRA.

- For information about health benefits for adjuncts, please go to www.laccd.edu/health
- To check your enrollment status, call the LACCD Health Benefits Call Center at (888) 428-2980.

FOR DISTRICT OFFICE USE ONLY

Form C-948:	Date Rec'd _____	Date Processed _____	By _____
Health Enrollment Forms:	Date Rec'd _____	Date Processed _____	By _____
Payment Due (): _____	Date Rec'd _____	Date Processed _____	By _____
Payroll Deduction:	Date Processed _____		By _____