SAN MATEO COUNTY COMMUNITY COLLEGE DISTRICT
Cañada College • College of San Mateo • Skyline College

ADJUNCT (Part-Time) FACULTY
MEDICAL REIMBURSEMENT PROGRAM

MEDICAL STIPEND FOR PART-TIME FACULTY: **Effective Fall 2017, the District is providing up to $1,505.00 of medical reimbursement per semester**, for reimbursement of **employee-incurred** health benefit costs to all part-time hourly academic employees who are employed and complete a 40% or more of a full-time load (6/15 FLC) in the District. The reimbursement periods for the fall and spring semesters are July through December and January through June.

The stipend shall be used to reimburse part-time faculty who qualify for reimbursement under these provisions for premium costs only from enrollment in any HMO, PPO, or indemnity health plan licensed and registered by either the California Department of Insurance or the California Department of Corporations.

Employees wishing to be reimbursed for medical expenses under this article must initiate the request on a District form. The employee must furnish documentation (cancelled check, paid statement) showing that the employee had been purchasing health insurance during the instructional period for which the employee was otherwise not eligible for reimbursement from any other source.

The reimbursement request must be ***received by Human Resources by***:
a) **December 31st** for the period covering July through December;
b) **June 15th** for the period covering January through June.

If you meet the requirements above and you wish to participate in the program, complete the Medical Reimbursement Request Form along with the required documentation. Submit the completed form to the Office of Human Resources for approval and processing.

Incomplete forms will be returned to employee and may delay payment.

SUBMIT FORMS TO HUMAN RESOURCES: Anahi Aguilar at aguilara@smccd.edu

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SAVE PRINT RESET

ADJUNCT (Part-Time) FACULTY
MEDICAL REIMBURSEMENT REQUEST FORM

EMPLOYEE NAME: (please print)_____ G#: _____

HOME ADDRESS: _____

HOME TELEPHONE:_____ E-MAIL: _____

COLLEGE:_____ DEPT./DIV:_____

** Checks will be mailed to home address**

Please check reimbursement request period

☐ **July 1 through December 31** Employed in Fall Semester Form due in Human Resources by Dec. 31	☐ **January 1 through June 30** Employed in Spring Semester Form due in Human Resources by Jun. 15

PART A: PROGRAM ELIGIBILITY (EMPLOYEE COMPLETES THIS SECTION)

Check all that apply:

☐ I have completed at least six (6) of 15 FLC (40% of full time) this semester.

☐ I am currently enrolled **and I am paying** premiums to the following medical plan:_____
The medical plan Group Number is: _____ Date first enrolled in this plan: _____
The premium costs are $_____ per ☐ month ☐ quarter ☐ year

☐ I am aware that per Education Code 87861 (a), benefits do not include vision or dental coverage.

☐ **I am aware that per Ed Code 87864, no part-time faculty member or dependents whose premiums for health insurance are through an employer other than a community college district is eligible to participate in this program established pursuant to this article.**

☐ In addition to my adjunct employment at SMCCCD, I also am employed by another California community college district. If yes, district name: _____

☐ I understand that the District will reimburse me pursuant to AFT Contract provisions & in accordance with Education Code provisions.

☐ **Copy of cancelled checks and proof of medical plan enrollment OR paid premium statements identifiable for each claimed month OR proof of medical plan enrollment and payments made for each claimed month.**
NOTE: Documents MUST have your name.

Amount submitted for reimbursement consideration: $_____ (Maximum reimbursement of $1,505.00)

Employee Signature: _____ **Date:** _____

PART B: ELIGIBILITY VERIFICATION (COMPLETED BY Human Resources ONLY) FTE: _____

☐ **Request for Program participation is approved. All of the required program criteria have been met and VERIFIED. Required proof of medical plan enrollment and premium payments are attached to this form.**

LABOR DISTRIBUTION (Reflects term of claim)
_____ - _____ -*3419 - _____ = **_____%
_____ - _____ -*3419 - _____ = **_____%
_____ - _____ -*3419 - _____ = **_____%

***Use acct 3459 if employee is in a non-instructional position.**
***Labor distribution must equal 100%.**

Human Resources Signature: _____ **Date:**_____