Cerritos College
11110 Alondra Boulevard, Norwalk, California 90650

PART-TIME FACULTY (Adjunct)
MEDICAL REIMBURSEMENT REQUEST FORM

EMPLOYEE NAME (please print):_____SEMESTER.: _____

DIV/DEPT: _____ EMAIL: _____

CONTACT TELEPHONE.:_____ OFFICE EXT: _____

PART A: PROGRAM ELIGIBILITY (to be completed by employee)

Eligibility: Part-time instructional Faculty will have completed at least a 30% load the same semester in which they are applying for reimbursement.

a) Part-time instructional Faculty will have completed at least a 30% load the same semester in which they are applying for reimbursement.
AND
b) Instructional Faculty must have taught at least 30% of a full-time load for at least three semesters within a three-year period, not including the semester in which applying for reimbursement.

c) Part-time non-instructional Faculty will have completed at least 175 total hours the same semester in which they are applying for reimbursement.
AND
d) Non-Instructional Faculty must have worked 175 total hours for at least three semesters within a three-year period, not including the semester in which applying for reimbursement.

Approved absences as reported on the Absence Certification form provided by the District count towards the total hours required for instructional and non-instructional computation. However, a minimum of 75% of the 175 total hours or 75% of the 30% load must be on a paid status.

I am requesting reimbursement for employee-incurred expenses as follows:

Medical Insurance Premium: **$** _____
OR
Doctor visits, procedures, labs, prescriptions: **$** _____

MEDICAL TOTAL: $ _____

Dental Insurance Premium: **$** _____
OR
Dental visits, procedures, labs, prescriptions: **$** _____

DENTAL TOTAL: $ _____

I certify that the expenses submitted for reimbursement have not already been reimbursed from any other source and any indication to the contrary may disqualify my participation in the Part-time Faculty Medical Reimbursement Program in the future.

Employee Signature: _____ Date: _____

PART B: ELIGIBILITY VERIFICATION (To Be Completed by Human Resources Only)	
Employee ID#:	**Date Request was received:**

☐ **YES. Request for reimbursement 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.

☐ **NO. Request for reimbursement is denied.**

Reason: _____

_____

Total amount approved: $_____ Date submitted to Payroll: _____

HR Staff Member Review: _____ Date: _____

HR Manager Approved: _____ Date: _____