Cerritos Community College District
Office of Human Resources

Part-Time Faculty Multidistrict Assignment Verification Form

Part-time Faculty at Cerritos College meeting the definition of "multidistrict part-time faculty" may submit documentation of individually purchased medical benefit coverage for partial reimbursement.

Multidistrict part-time faculty are defined as faculty with assignments at two (2) or more California community college districts that when added together is equal to or greater than forty (40%) percent of a full-time faculty assignment. To be eligible for health insurance reimbursement for a portion of their paid medical insurance premium, part-time faculty at Cerritos College must verify their multidistrict assignments for the semester in which they are requesting reimbursement of a portion of the cost of their medical premiums.

1. **Employee Information:** Part-time faculty should complete **all** sections below.

Employee Last Name:	Employee First Name:	Employee ID #:
Cerritos College Email Address:	Semester of Verification:	Phone:

2. **Multidistrict Assignment Information:** Part-time faculty should provide this form to each additional District they hold an assignment with to verify their load for the semester indicated above. Verification of assignments should be processed by Human Resources personnel at each District and may be subject to verification.

District 1

College/District Name:	Total FTE %:	Is the employee currently enrolled in a medical plan with your district? (circle one)
		Yes **No**
Verified By (Name):	Title of Verification Provider:	Signature:

District 2

College/District Name:	Total FTE %:	Is the employee currently enrolled in a medical plan with your district? (circle one)
		Yes **No**

Verified By (Name):	Title of Verification Provider:	Signature:

District 3

College/District Name:	Total FTE %:	Is the employee currently enrolled in a medical plan with your district? (circle one) **Yes** **No**

Verified By (Name):	Title of Verification Provider:	Signature:

I hereby certify that I am not otherwise eligible for or enrolled in health care coverage, as an employee, spouse, domestic partner, or dependent, under a health insurance program sponsored or paid, in full or in part, by another organization.

I understand that I must meet the eligibility criteria, submit this completed verification form, and submit the required supporting documentation in order to be reimbursed for a portion of the cost of my medical premiums.

By signing below, I acknowledge and agree to the above information. I certify that all information provided on this certification form is true and correct and understand that this information will be verified by Cerritos Community College District's Office of Human Resources.

Employee Signature	Date