san josé·evergreen
COMMUNITY COLLEGE DISTRICT

HUMAN RESOURCES SERVICES GROUP

▪ Forty South Market Street ▪ San José, CA 95113 408-223-6713 ▪ 408-239-8804 (fax)

Associate Faculty – Kaiser Permanente Plan

Verification of Eligibility Form

Spring 2024

Required:

Name:_____ (Print)

Employee Number: _____ **Phone Number**: _____

Campus: _____**EVC** _____**SJCC** **Division**: _____

☐ **This is a NEW enrollment.** I was **not** enrolled in a District Plan fall '23. (*Plan A or Plan B enrollment form is required)*

☐ **I wish to CONTINUE my current coverage in spring 2024 I did fall 2023,** (no changes. *(Only this form is due.)*

☐ **I wish to SWITCH my coverage in spring 2024 from Plan A to Plan B.** (A Plan B enrollment form is required.)

☐ **I was enrolled fall 2023 but will not qualify OR wish to CANCEL my coverage effective 03/01/2024.**

I ELECT TO ENROLL IN OR CONTINUE THE FOLLOWING PLAN (please check ONE box):

	Employee Only	Employee + Spouse	Employee + Domestic Partner	Employee + Child/Children	Family
TRADITIONAL PLAN (PLAN A)	☐	☐	☐	☐	☐

	Employee Only	Employee + Spouse	Employee + Domestic Partner	Employee + Child/Children	Family
DEDUCTIBLE PLAN (PLAN B)	☐	☐	☐	☐	☐

I attest by my signature below that I meet the following eligibility criteria listed and agree to the following:

a) I meet the eligibility for coverage criteria under Article 9.2.3 of the AFT Collective Bargaining Unit;
b) I will not have any other coverage, nor will my dependents (if enrolling/enrolled);
c) I agree to pay 100% of the premium for any eligible dependent I enroll.

I authorize payroll to deduct the dependent (if applicable) portion of the plan premium from my paychecks.

Signed: _____ **Date:** _____

For HR Only:

Eligibility Verified: _____ Processed SISC ☐ Benetrac ☐ Colleague ☐