Contra Costa Community College District Human Resources Department
Part-Time Faculty Medical Benefits Affidavit for Enrollment

To be completed by every part-time faculty member who enrolls in District Benefits at the time of enrollment.

TO BE COMPLETED BY ENROLLING PART-TIME FACULTY

I hereby certify under PENALTY OF PERJURY under the laws of the State of California that while I am covered by health insurance through Contra Costa Community College District, I will not have other medical insurance where all or part of the premium is paid by another source either directly, as a spouse, as a domestic partner, or as a dependent. I further certify that no spouse or dependent that will be covered under my plan through the Contra Costa Community College District program is receiving or will receive health insurance from another source simultaneously, and that the information I have provided to the District in this Affidavit is true and correct.

I agree that if my status changes after I have signed this Affidavit in that I or my spouse or dependents enroll in other medical insurance where all or part of the premium is paid through some other source, I will immediately inform the District by emailing District Human Resources at Benefits@4cd.edu.

_____ _____ _____
Name of Employee (print) Employee ID or SSN Date of Birth

_____ _____ _____ _____
Street Address City State Zip Code

_____ _____
Home Phone Email

_____ _____
Signature of Employee Date Signed