



## Part-time Faculty Health Insurance Application/Affidavit

I declare, as a part-time faculty member, that I am enrolled in and responsible for the monthly premium cost of a voluntary Bronze, Silver, Gold or Platinum medical plan provided through Covered California under the Patient Protection and Affordable Care Act, or an equivalent comprehensive medical or health insurance plan.

In addition, I understand that I am required, each semester, to submit this Application/Affidavit along with proof of medical coverage to the Human Resources Office electronically via [HRPTFInsurance@socccd.edu](mailto:HRPTFInsurance@socccd.edu) no later than September 10<sup>th</sup> for the Fall Semester and February 10<sup>th</sup> for the Spring Semester by 5 p.m. (PST) in order to be eligible for the District allowance.

Employee ID: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State Zip: \_\_\_\_\_

I declare under penalty of perjury under the laws of the State of California that the above is true and correct and I am paying \$\_\_\_\_\_ per month, or \$\_\_\_\_\_ per year, for comprehensive medical coverage during the current semester for myself.

\_\_\_\_\_  
**Signature of Declarant**

\_\_\_\_\_  
**Date**

**Attached forms:**  Proof of Medical Coverage (including coverage dates)  
 Proof of Cost for Part-time Faculty member ONLY

HR Revised 01.12.2021