28000 Marguerite Parkway, Mission Viejo, CA 92692-3635 • 949.582.4999 • FAX 949.364.2726 • www.socccd.edu
Saddleback College • Irvine Valley College • Advanced Technology & Education Park

Part-time Faculty Health Insurance Application/Affidavit

I declare, as a part-time faculty member, that I am enrolled in and responsible for the 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 no later than September 10th for the Fall Semester and February 10th 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 only.

_____ _____

Signature of Declarant **Date**

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

HR Revised 01.14.2022