COLLEGE OF THE REDWOODS

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ASSOCIATE FACULTY MEDICAL REIMBURSEMENT PROGRAM

MEDICAL STIPEND FOR ASSOCIATE FACULTY: **The District provides up to $1,000.00 of medical reimbursement per semester** for reimbursement of **employee-incurred** health benefit costs to all part-time hourly academic employees who are currently employed by the District and complete a 40% or more of a full-time load in the District. The reimbursement periods for the fall and spring semesters are July 1 through December 31 and January 1 through June 30.

The stipend shall be used to reimburse associate faculty who qualify for reimbursement under these provisions for premium costs only from enrollment in any HMO, PPO, or indemnity health plan licensed and registered by either the California Department of Insurance or the California Department of Corporations.

Employees wishing to be reimbursed for medical expenses under this article must initiate the request on the Associate Faculty Medical Reimbursement Request Form. The employee must furnish documentation from either the insurance company or employer showing that the employee purchasing health insurance during the instructional period for which the employee was otherwise not eligible for reimbursement from any other source. This request is to be submitted only to the Payroll Office for approval and processing of the reimbursement.

The reimbursement request must be ***received by the Payroll Office by***:
a) **December 15th** for the period covering July through December;
b) **June 15th** for the period covering January through June.

If you meet the requirements above and you wish to participate in the program, complete the Associate Faculty Medical Reimbursement Request Form along with the required documentation. Submit the completed form to the Payroll Office for approval and processing.

ASSOCIATE FACULTY
MEDICAL REIMBURSEMENT REQUEST FORM

EMPLOYEE NAME: (please print)_____ ID#: _____

MAILING ADDRESS: _____

TELEPHONE:_____ E-MAIL:_____

** Checks will be mailed to mailing address noted above.**

Please check reimbursement request period

☐ **July 1 through December 31** Employed in Fall Semester Form due in the Payroll Office by Dec. 15	☐ **January 1 through June 30** Employed in Spring Semester Form due in the Payroll Office by Jun. 15

PART A: PROGRAM ELIGIBILITY (to be completed by employee)

Check ALL that apply:

☐ I have completed at least 40% of a full-time load this semester (as per Ed Code 87861(b)).

☐ I am currently enrolled **and I am paying** premiums to the following medical plan:
The medical plan Group Number is: _____ Date first enrolled in this plan: _____
The premium costs are $_____ per ☐ month ☐ quarter ☐ year

☐ I am aware that per Education Code 87861 (a), benefits do not include vision or dental coverage.

☐ **I am aware that per Ed Code 87864, no part-time faculty member or dependents whose premiums for health insurance are paid through an employer other than a community college district is eligible to participate in this program established pursuant to this article.**

☐ In addition to my adjunct employment at College of the Redwoods, I also am employed by another California community college district (Yes or No?) If yes, district name: _____

☐ I understand that the District will reimburse me pursuant to CRFO/RCCD contract provisions & in accordance with Education Code provisions.

☐ Documentation from either the insurance company or employer
Note: All documents must have your name and the name of medical plan.

Amount submitted for reimbursement consideration: $_____ (Maximum reimbursement of $1,000.00)

Employee Signature: _____ Date: _____

PART B: ELIGIBILITY VERIFICATION (to be completed by the Payroll Office ONLY)

☐ **Request for Program participation is approved. All of the required program criteria have been met and VERIFIED. Required proof of medical plan enrollment and premium payments are attached to this form.**

Amount approved for reimbursement: $_____

Payroll Office Signature: _____ Date:_____

REV 01/2017