AFFIDAVIT STATEMENT

I hereby declare under penalty of perjury under the laws of the State of California that I have no other access to medical insurance, excluding Medicare, where all or part of the premium is paid through some other source and that the information I have provided to the District in this Affidavit is true and correct.

_____   _____   _____
Name of Employee (print)   Social Security Number   Date of Birth

_____   _____   _____   _____
Street Address   City   State   Zip Code

_____   _____   _____
Home Phone   Work Phone   E-Mail Address

_____   _____
Signature of Employee   Date

==

State of   _____

County of   _____

On _____   Before me, _____
             Date   Name and Title of Officer (e.g., "Jane Doe, Notary Public)

Personally appeared   _____
                                                         Name(s) of Signer(s)

☐ Personally known to me
☐ Proved to me on the basis of satisfactory evidence

to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

WITNESS my hand and official seal,

_____   _____
Signature of Notary Public   Date

Selection and Agreement for Benefit Plan Year
(October 1, 2009 – September 30, 2010)

The Foothill-De Anza Community College District has agreed to provide 100% of the monthly premium for the District's Kaiser Foundation Health Plan. I have selected the **Kaiser Foundation Health Plan** as checked below:

CHOOSE ONE: (9 monthly contributions for 12 months of coverage)

	Monthly for 9 months:	Less: District Contribution (100% of Kaiser rates)	PT Faculty Contribution
☐ Member Only	$ 689.59	($ 689.59)	$0.00
☐ Member + One Dependent	$1,379.17	($1,379.17)	$0.00
☐ Member + Family	$1,951.52	($1,951.52)	$0.00

The above premiums are effective from July 1, 2009 through June 30, 2010. The monthly premium rate will remain constant from October 1, 2009 through June 30, 2010. The monthly payment is adjusted each **July 1st** as the premium is subject to change.

_____   _____
Signature of Employee   Date

FAX: (650) 949-2831   DEADLINE: FRIDAY, JULY 31, 2009

For office use only:
KAISER Plan: 100% ERC   Benefits Code: _____   Plan Code: _____   Coverage Code: _____   F2