

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 _____ Date Before me, _____ 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 50% of the monthly premium for the District's Kaiser Foundation Health Plan. I authorize Foothill-De Anza Community College District to deduct **50%** of the monthly premium for the **Kaiser Foundation Health Plan** as checked below:

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

	Monthly for 9 months:	<u>PT Faculty (50% Contribution)</u>
<input type="checkbox"/> Member Only	\$ 689.59	(\$344.79)
<input type="checkbox"/> Member + One Dependent	\$1,379.17	(\$689.59)
<input type="checkbox"/> Member + Family	\$1,951.52	(\$975.76)

The above premiums are effective from July 1, 2009 through June 30, 2010. The monthly deduction 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: 50% EEC

Benefits Code: _____ Plan Code: _____ Coverage Code: _____ F1