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)

Who proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the within instruments and acknowledged to me that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument the person, or the entity upon half of which the person acted, executed the instrument

I certified under the PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

Witness my hand and official seal.

_____ (NOTARY SEAL)
Signature of Notary Public

Description of attached document

☐ AFFIDAVIT STATEMENT FOR HEALTH COVERAGE

Selection and Agreement for Benefit Plan Year
(October 1, 2010 – September 30, 2011)

The Foothill-De Anza Community College District has agreed to provide 68 percent of the monthly premium for the District's Kaiser Foundation Health Plan. I authorize Foothill-De Anza Community College District to deduct the monthly premium for the **Kaiser Foundation Health Plan** as checked below:

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

	PT Faculty (32% Contribution)
☐ Member Only	**($232.00)**
☐ Member + One Dependent	**($465.33)**
☐ Member + Family	**($658.67)**

The above premiums are effective from July 1, 2010 through June 30, 2011. The monthly deduction rate will remain constant from October 1, 2010 through June 30, 2011. The monthly payment is adjusted each **July 1st** as the premium is subject to change.

_____ _____
Signature of Employee Date

FAX: (650) 949-2831 **DEADLINE: Thursday, July 29, 2010**

For office use only:
KAISER Plan: 32% EEC Benefits Code: _____ Plan Code: _____ Coverage Code: _____ F1