

**AFFIDAVIT STATEMENT  
FOR PAID BENEFITS FOR PART-TIME FACULTY  
(0.400 – 0.499 Load)**

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) CWID Date of Birth

\_\_\_\_\_  
Street Address City State Zip Code

\_\_\_\_\_  
Home Phone Work Phone District Assigned 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.

\_\_\_\_\_  
Signature of Notary Public (NOTARY SEAL)

**Description of attached document**

☐ AFFIDAVIT STATEMENT FOR HEALTH COVERAGE

**Selection and Agreement for Benefit Plan Year  
(October 1, 2011 – September 30, 2012)**

The Foothill-De Anza Community College District has agreed to provide 50 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 (50% Contribution)**

<input type="checkbox"/> Member Only	<b>(\$364.00)</b>
<input type="checkbox"/> Member + One Dependent	<b>(\$726.67)</b>
<input type="checkbox"/> Member + Family	<b>(\$1,029.33)</b>

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 1<sup>st</sup>** as the premium is subject to change.

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date

**FAX: (650) 949-2831**

**DEADLINE: Thursday, July 28, 2011**

For office use only:

**KAISER Plan: 50% EEC**

Benefits Code: \_\_\_\_\_ Plan Code: \_\_\_\_\_ Coverage Code: \_\_\_\_\_ F2