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 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 _____

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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, 2006 – September 30, 2007)

I authorize Foothill-De Anza Community College District to deduct the difference in monthly premium between the cost of the District Combined Coverage Medical Plan (PPO+) and the Kaiser Medical Plan. I have elected the District Combined Coverage Medical Plan (PPO+) as checked below:

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

	Monthly for 9 months:	LESS: District Contribution (50% of Kaiser rates)		PT Faculty Contribution:
☐ Member Only	$ 805.83	($270.43)		$535.40
☐ Member + One Dependent	$1,620.01	($540.86)		$1,079.15
☐ Member + Family	$2,381.05	($765.31)	$1,615.76	

The above premiums are effective from July 1, 2006 through June 30, 2007. The monthly deduction rate will remain constant from October 1, 2006 through June 30, 2007. The monthly payment is adjusted each **July 1st** as the premium is subject to change.

_____ _____
Signature of Employee Date

FAX: (650) 949-2831 *DEADLINE: MONDAY, JULY 31, 2006*

For office use only:

PPO+ Plan: 50% EEC Benefits Code: Plan Code: Coverage Code: F3