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)

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 for the Plan Year 2006-2007 as checked below:

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

	Monthly for 9 months:	PT Faculty Contribution:	100% District Contribution:
☐ Member Only	$ 540.85	$0.00	$ 540.85
☐ Member + One Dependent	$1,081.71	$0.00	$1,081.71
☐ Member + Family	$1,530.61	$0.00	$1,530.61

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:
KAISER Plan: 100% ERC Benefits Code: _____ Plan Code: _____ Coverage Code: _____ F2