

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

=====
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 Network Only (PPO) Plan and the Kaiser Medical Plan. I have elected the District Network Only Plan (PPO) as checked below:

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

	Monthly for 9 months:	LESS: District Contribution: (100% of Kaiser rates)	PT Faculty Contribution:
<input type="checkbox"/> Member Only	\$ 635.20	(\$540.85)	\$ 94.35
<input type="checkbox"/> Member + One Dependent	\$1,245.79	(\$1,081.71)	\$164.08
<input type="checkbox"/> Member + Family	\$1,891.87	(\$1,530.61)	\$361.26

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
FAX: (650) 949-2831

Date
DEADLINE: MONDAY, JULY 31, 2006

For office use only:

PPO NTWK Plan: 100% ERC Benefits Code: _____ Plan Code: _____ Coverage Code: _____ F6