FOOTHILL-DE ANZA
COMMUNITY COLLEGE DISTRICT

Multidistrict Part-time Faculty Health Insurance
Application For Reimbursement

Checklist

Before submitting your application for reimbursement, make sure you have all of the following saved in **electronic** form:

- ❑ Reimbursement Application Form
- ❑ One signed Load Verification Form **for each** California Community College district (including FHDA) that you are employed by during the reimbursement period.
  The form for FHDA is different from the form needed for non-FHDA districts.
  For FHDA forms, Foothill faculty should have the form signed by Nury Akylbekova and De Anza faculty should have the form signed by Jiatong Li.
- ❑ Proof of your enrollment in the benefits plan listed on the application.
- ❑ Proof of payment for the benefits plan for the period of reimbursement.

When you have all the documents together, scan and email the entire packet (all documents) to MyBenefits@fhda.edu.

FOOTHILL-DE ANZA
COMMUNITY COLLEGE DISTRICT

Multidistrict Part-time Faculty Health Insurance
Application For Reimbursement
(California Community Colleges Medical Health Insurance Reimbursement Program)

Employee Name:_____ CWID: _____

District Email Address: _____ Phone #: _____

Campus: ☐ Foothill ☐ De Anza ☐ Both

Division(s)_____ Department(s)_____

Period of Reimbursement Requested: ☐ July – December, 2026
☐ January – June, 2027

I certify that the following conditions have been met: (please initial in front of each section)

_____
Initial here

1. I currently teach a 40%+ combined load at two or more California community college districts (CCD), including Foothill - De Anza CCD ***AND*** I do not teach a 40% or greater load at any single California community college district that offers medical coverage equivalent to that offered to full-time faculty. (Documentation of workload must be attached to this application.)

   I currently teach at the following California community colleges districts.

   CCD 1:
   Foothill-De Anza _____% **(**workload verification on separate form attached)

   CCD 2:

   _____% (workload verification on separate form attached)

   CCD 3:

   _____% (workload verification on separate form attached)

   CCD 4:

   _____% (workload verification on separate form attached)

_____ *Initial here*

2. No other employer or agency other than a California community college district is paying fo my health insurance. I am not eligible for employer provided benefits through a spouse or domestic partner.

_____ *Initial here*

3. I am currently enrolled in the _____ (name of insurance) plan and I currently pay

$_____ for the coverage period (July – December, 2026 or January – June, 2027).

The coverage is for:

- ○ Myself
- ○ Myself + 1
- ○ Myself + Family

Does the coverage include a domestic partnership?

- ○ Yes
- ○ No

_____ *Initial here*

4. I understand the following provisions of this program:
   A. I cannot be reimbursed more than the proportionate share of the cost of the district's most commonly subscribed coverage plan.
   (2026 Kaiser: EE only $1,045.86/mo , EE + 1 $/2,021.72/mo, or EE + Family $2,629.04/mo)
   B. Reimbursements are made once every coverage period.
   (July – December 2026 reimbursement made: January 15th ,2026; January – June 2027 reimbursement made: July 15th, 2027.)
   C. No applications will be accepted after the submission deadline.
   July – December 2026 documentation accepted between Nov 13 and December 11, 2026. Deadline is Dec 11, 2026.
   January - June 2027 documentation accepted between May 14 and June 11, 2027. Deadline is June 11, 2027.
   D. The District requires verification of coverage and proof of premium payment for reimbursement.

_____ *Initial here*

5. I have attached my premium invoice(s) and proof of payment to this application.
   - Reimbursement Period 1: July – December 2026
   - Reimbursement Period 2: January – June 2027

_____ *Initial here*

6. I have attached proof of load taught at all districts using the verification form. *(Proof must be submitted on the Part-time Faculty Health Insurance Multi-District Load Verification form provided by FHDACCD and each one MUST be signed by an authorized representative from the College to be eligible for consideration. An authorized repres entative could include Human Resources staff, manager/dean of your department, Office of Instruction staff.)*

Comments:

Employee Signature	Date

Please return this and all supporting documentation to: MyBenefits@fhda.edu

No later than two weeks prior to the end of the coverage period

(Fall deadline: December 11th, 2026; Winter/Spring deadline: June 11th, 2027)

Please do not submit paper forms; electronic formats only will be accepted as complete .

ELIGIBILITY VERIFICATION *(To be completed by District Benefits Office only)*

FHDA Percentage: Fall load / 0.333 =_____% or (Winter+ Spring load) / 0.666 = _____%_

District 2 Percentage from attached form: _____

District 3 Percentage from attached form: _____

District 4 Percentage from attached form: _____

Total Percentage (add all of the above): _____

○ YES. Request for reimbursement is approved. All of the required program criteria have been met and VERIFIED. Required proof of medical plan enrollment, premium payments, and teaching load are attached to this form.

○ NO. Request for reimbursement is denied.
Reason:

Number of Districts including FHDA: _____

Total employee expense for 6 month period:_____ (proof attached)

Proportionate amount due to employee*:

(Total Premium/ number of districts) * 85% = _____

*maximum amount:
EE only $1045.86/mo = $6,275.16 for 6 months
EE + 1 $2021.72/mo = $12,130.32 for 6 months,
EE + Family $2629.04/month = $15,774.24 for 6 month

Total amount approved: $_____ Processed and Approved by: _____

Date:

FOOTHILL-DE ANZA
COMMUNITY COLLEGE DISTRICT

PART-TIME FACULTY HEALTH INSURANCE MULTI-DISTRICT LOAD VERIFICATION

(California Community Colleges Health Insurance Reimbursement Program)

Education Code sections 87860 through 87868 establish the Part-Time Community College Faculty Health Insurance Program to encourage community college districts to offer health insurance for part-time faculty. The program does not cover the cost of dental or vision premiums. Multidistrict part-time faculty are those with total teaching assignments at two or more community college districts equal to or greater than 40 percent of a full-time assignment.

Directions: *Submit this form to verify your workload in FHDA. This form will be used to confirm your eligibility for the program as a multi-district part-time faculty member.*

Employee Name	FHDACCD CWID
Employee Signature	Date

Please have your Foothill or De Anza campus HR representative complete the "Workload Verification" section below for use in calculating your total load, as a percentage of Full-time, for part-time medical health benefit premium reimbursement from Foothill-De Anza CCD.

FHDA Workload Verification

Quarters at FHDA	Fall Load Factors _____/ 0.333 =_____ % of a Full-time (September-December) or Winter Load _____ and Spring Load _____ (Winter Load +Spring Load) / 0.666 = _____% of Full-time (January – June)

Foothill- De Anza Community College District	
California Community College/District	
Signature of Campus HR	Date
Print Name & Title	Phone
Email	

FOOTHILL-DE ANZA
COMMUNITY COLLEGE DISTRICT

PART-TIME FACULTY HEALTH INSURANCE MULTI-DISTRICT LOAD VERIFICATION

(California Community Colleges Health Insurance Reimbursement Program)

Education Code sections 87860 through 87868 establish the Part-Time Community College Faculty Health Insurance Program to encourage community college districts to offer health insurance for part-time faculty. The program does not cover the cost of dental or vision premiums. Multidistrict part-time faculty are those with total teaching assignments at two or more community college districts equal to or greater than 40 percent of a full-time assignment.

Directions: *Submit one form for each of the California Community Colleges (other than FDHA) that you are employed by in the current semester/quarter. This form will be used to confirm your eligibility for the program as a multi-district part-time faculty member.*

Employee Name	FHDACCD CWID
Employee Signature	Date

Please have each of your non-FHDA community college employers complete the "Workload Verification" section below for use in calculating your total load, as a percentage of Full-time, for part-time medical health benefit premium reimbursement from Foothill-De Anza CCD.

Non- FHDA District(s) Workload Verification

Semester	Fall Workload (% of a Full-time semester)_____ or Spring Workload (% of a Full-time semester) _____
Quarter (only if Lake Tahoe CCD)	Fall Workload (% of a Full-time quarter)_____ or Winter Workload (% of a Full-time quarter)_____ and Spring Workload (% of a Full-time quarter)_____

California Community College/District	
Signature of School Official	Date
Print Name & Title	Phone
Email	

This form must be submitted with the application packet.