



PT FACULTY INSURANCE CERTIFICATION (MINIMUM LOAD/ASSIGNMENT 40%, .4FTE)

| Employee Information: Please complete all sections below. | | |
|---|---------------------|---------------|
| Employee Last Name | Employee First Name | Employee ID # |
| District Issued Email | Phone | Current Term |
| Campus | Department | |

| Multi-District Assignment Verification: Please complete all sections below. | | |
|---|--------------------------------|-----------|
| College Name | Verified By (Name) | Signature |
| Total FTE % | Title of Verification Provider | |
| College Name | Verified By (Name) | Signature |
| Total FTE % | Title of Verification Provider | |
| College Name | Verified By (Name) | Signature |
| Total FTE % | Title of Verification Provider | |

Note: Please use multiple forms if you require additional verifications.

I have read the requirements for LBCCD medical enrollment eligibility as outlined in the Memorandum of Understanding (MOU), dated December 4, 2023, between LBCCD and CHI. I certify that I am eligible to participate.

I hereby certify that I am not otherwise eligible for or enrolled in health care coverage, as an employee, spouse, domestic partner, or dependent, under a health insurance program sponsored or paid, in full or in part, by another organization.

I understand that I must submit this completed certification form and the required supporting documentation by February 20, 2024.

By signing below, I acknowledge and agree to the above information. I certify that all information provided on this certification form is true and correct and understand that this information will be verified by LBCCD Human Resources.

Employee Signature

Date