Long Beach County Community College District
4901 E. Carson Street, Long Beach, CA 90808
Human Resources | Benefits Office | Email: chibenefits@lbcc.edu

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**