Part-Time Faculty Medical Insurance Reimbursement Application

Your union has negotiated for a fund that sets up a basic plan for reimbursing ***part-time faculty*** for a portion of their quarterly medical insurance premiums.

IF YOU ARE A PART-TIME CGCC FACULTY MEMBER, you must submit this form (with EVERY blank ACCURATELY COMPLETED) along with evidence of payment of premiums by the deadline below in order to apply for reimbursement of medical insurance premiums you have paid this term. Reimbursement is for your individual premiums ONLY. Premiums that you paid to cover spouses and other family are not reimbursed by this Union fund.

Please be sure your evidence of premiums paid demonstrates that you paid the premium(s) during the term in which you are applying, and that these premiums are for you only.

Late or incomplete applications will not be considered. (If you do not know which CGCC Pay Level you are, request that information from Diane Trubachik in the CGCC Business Office.)

To apply for reimbursement, (1) fill out a form (below) for each term, and (2) return it before each term's deadline, and (3) include the required premium payment evidence, to:

United Employees of Columbia Gorge Community College
P.O. Box 1106, The Dalles, OR 97058

Medical Insurance Reimbursement Application Deadlines			
Fall Term	**Winter Term**	**Spring Term**	**Summer Term**
December 1	March 1	June 1	August 1

There is no grace period for missed deadlines.

----------[detach here] ----------

APPLICATION FOR INSURANCE PREMIUM REIMBURSEMENT

Name_____ School Year: _____ Term: Fall Winter Spring Summer
(Circle One)

Number of credit hours scheduled to teach at CGCC in the current term: _____
(Note: 20 BSD hours = 1 credit hour)

Did you teach at CGCC in 2 of the past 3 terms (including summer)? Yes ____ No ____ (Check One)

CGCC Faculty Pay Level: 1 2 3 4 5 (Circle ONE) (NOTE: see page 24 of bargaining agreement for Pay Level info and/or contact Diane Trubachik, the CGCC Payroll Accountant at (541) 506-6054.)

Do you have another source of fully paid medical coverage (e.g. spousal coverage)? Yes ____ No ____
(Check One)

Do you have another source of partially paid medical coverage (e.g. Medicare)? Yes ___ No ___
(Check One)

Amount of individual monthly premium (if you have family coverage, you must determine and enter your individual portion here): _____

_____ (<=Your Signature Here) _____ (Date)

By signing this application, you are verifying that every statement and all information you provided on this form is correct. Your signature also indicates that you understand that incomplete applications will not be considered and will result in no reimbursement for this term.

Please provide evidence of your monthly premium with your application. If your application is not accompanied by the required evidence, your application will be considered incomplete.

For AFT Union Local 4764 Office Use Only rev. 06/08/09
Application Completely Filled In: Yes ___ No ___ Proof of Ins. Prem. Payment Received: Yes ___ No ___