Yosemite Community College District-Human Resources
Phone (209) 575-6505 www.yosemite.edu

APPLICATION FOR PART TIME FACULTY HEALTH REIMBURSEMENT

Reimbursement Semester Requested: _____

Load verification, please select one of the following:	
☐	I currently teach a minimum of 40% load at YCCD only.
☐	I currently teach a minimum of 40% combined load at two or more districts. List the districts:

☐ I understand the following provisions of this program:

1. The $6,000.00 maximum reimbursement per semester will be paid to me; it will not be forwarded to any insurance carrier or other 3rd party.
2. For the July 1-December 31 verification period, reimbursement request must be submitted on or before January 31 and shall be paid on or before March 31. For the January – June 30 verification period, reimbursement requests must be submitted on or before July 31 and shall be paid on or before September 30th.
3. Reimbursements will be issued approximately 30 to 60 days after all documentation has been received and approved by the district.
4. The District may request verification of coverage.
5. Part-time faculty are responsible for obtaining coverage on their own, and shall be required to provide proof of out-of-pocket insurance premium costs, and if multi-district, proof of load from all other districts to be eligible for reimbursement. YCCD load shall be verified by the District.
6. No other employer or entity is paying the portion of my health insurance premium that I am submitting for reimbursement from YCCD.

I have attached my premium invoice(s) and proof of payment to this form for health insurance coverage that was in effect during the applicable semester.

I have attached the following:

☐ 1: Proof of premium invoices and payment ☐ 2: Proof of load taught at other Districts (if applicable)

Printed Name:	Signature:
Phone Number:	Date:
Address: City/State Zip	

For Human Resources Only / Eligibility Verification:	
☐ Yes, eligibility criteria has been met and request for reimbursement is approved. All 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, eligibility criteria has not been met and request for reimbursement is denied.
Total Amount Approved: $	Date Submitted to Accounts Payable:
HR Staff Review:	Date:
HR Manager Approved:	Date