

**APPENDIX K
PAID BENEFITS FOR PART-TIME FACULTY
(Article 22A – Paid Benefits for Part-time Faculty)
Foothill-De Anza Community College District**

**SAMPLE Affidavit for Enrollment and Authorization for Payroll Deductions
(The document for the current year is available from the Office of Human Resources.)**

I hereby declare under penalty of perjury under the laws of the State of California that I have no other access to medical insurance where all or part of the premium is paid through some other source and that the information I have provided to the District in this Affidavit is true and correct.

Name of Employee (print) Social Security Number Date of Birth

Street Address City State Zip Code

Home Phone Work Phone

Signature of Employee

State of _____

County of _____

On _____ Before me, _____
Date Name and Title of Officer (e.g., "Jane Doe, Notary Public")

Personally appeared _____
Name(s) of Signer(s)

- Personally known to me
- Proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

WITNESS my hand and official seal,

Signature of Notary Public

Authorization and Agreement for Payroll Deductions

I authorize Foothill-De Anza Community college District to deduct 50% of the monthly premium for the District's Kaiser Medical Plan as checked below:

Choose One: (9 monthly contributions for 12 months of coverage)

	Monthly for 9 months:	PT Faculty Contribution:
<input type="checkbox"/> Member Only:	TBD	TBD
<input type="checkbox"/> Member + One Dependent	TBD	TBD
<input type="checkbox"/> Member + Family	TBD	TBD

The above premiums are effective from July 1, 20____ through June 30, 20____. Your monthly deduction rate will remain constant from October 1 through June 30. In addition, your monthly payment is adjusted each **July 1st** as premium is subject to change.

Signature of Employee _____ Date _____