North Orange County Community College District
1830 W. Romneya Drive, Anaheim, CA 92801
Human Resources | Benefits Office | Phone: 714-808-4800

MULTI-DISTRICT ADJUNCT FACULTY HEALTH INSURANCE CERTIFICATION FORM

Employee Information: Please complete **all** sections below.		
Employee Last Name	Employee First Name	Banner ID
District Issued Email	Phone	Current Term
Campus	Division	Department

Medical Coverage Information: Please complete **all** sections below.		
Medical Provider	Monthly Premium	Coverage (*i.e. Single, One Dependent, Family*)

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

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

I have read the requirements for NOCCCD eligibility as provided in the Multi-District Adjunct Faculty Health Insurance Reimbursement Program and the Adjunct Faculty Memorandum of Understanding (MOU), dated March 20, 2024, between Adjunct Faculty United and NOCCCD. I certify that I am eligible to participate in the Multi-District Adjunct Faculty Health Insurance Reimbursement Program.

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 employer.

I understand that I must submit this completed certification form and the required supporting documentation by the last day of the semester for which I am applying. All requests for reimbursement shall be conducted through the District's designated online application process.

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 this information will be verified by NOCCCD Human Resources.

_____ _____

Employee Signature **Date**