CHAFFEY COMMUNITY COLLEGE DISTRICT
PART-TIME INSTRUCTOR MEDICAL/DENTAL BENEFITS
PROGRAM APPLICATION FOR REIMBURSEMENT

Reimbursement for Semester (choose one): Fall: _ 2023 _____ Spring: _ 2024 _____

I certify that each of the following conditions have been met:

1. Have a regularly scheduled assignment during each term of my participation in this program; and
2. Have had a regularly scheduled assignment at the District for at least two (2) primary terms immediately prior to the first term of my participation in this program.

I understand the following provisions of this program:

1. The $600 maximum reimbursement per eligible semester will be paid to me; it will not be forwarded to any insurance carriers or other 3rd party.
2. Completed application and supporting documentation (verification of insurance payment or out-of-pocket expense) must be submitted within 30 days of the cost being incurred.
3. Reimbursements are made on a first come-first served basis until funds are exhausted.
4. When the designated allotment has been exhausted, medical/dental benefits reimbursement will no longer be funded.
5. Reimbursement checks will be sent via USPS approximately 2-3 weeks after the required documentation has been received and approved by the District. Reimbursement can be issued as a direct deposit if a Vendor EFT enrollment form is completed. Form is available on the Z drive at: Z:\Accounting Services\Public\Accounting Services\Forms\Vendor EFT Enrollment Form (rev1 2021-1028).pdf. Claims will not be processed for reimbursement until all required documentation has been received.
6. Reimbursement is not available for co-pays or elective cosmetic treatments.

I have attached my supporting documentation to this form confirming payment for services or premiums during the applicable semester. By signing below, I confirm the services and/or premium payment secured are for me and medical services were provided by a licensed medical practitioner.

Signature: _____ Date: _____

Employee ID: _____ Name: _____

Mailing Address: _____

_____

Email: _____

Requested Reimbursement Amount: _____ Date Medical Services Received: _____

FOR HR/ACCOUNTING USE ONLY:

HR Authorization: _____ Date: _____

HR Approved Reimbursement Amount: _____ Budget Number: _____

Accounting Authorization: _____