

# Part Time Faculty Medical Re-Enrollment



**West Valley - Mission**  
Community College District

I request to continue my enrollment in medical coverage, and I certify the following by checking these boxes:

- I confirm that an employer other than a California community college district is not paying health insurance premiums for me or my enrolled dependents during the Coverage Period

Fall Coverage Period: November through April  
Spring Coverage Period: May through October

- I understand that as a result of beginning a new eligibility period I may change my medical plan by submitting a completed CalPERS HBD-12 enrollment form
- I understand that if I wish to waive coverage I must submit a completed CalPERS HBD-12 waiver form

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Print Name

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Signature

Date

**Email your signed and completed form to: [danielle.ramirez-king@wvm.edu](mailto:danielle.ramirez-king@wvm.edu)**