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

Signature Date

Email your signed and completed form to the Benefits Specialist at:
melissa.duran@wvm.edu