Victor Valley Community College District
Office of Human Resources
18422 Bear Valley Road
Victorville, CA 92395
760-245-4271 Ext 2500

Part-Time Faculty Medical Reimbursement Request Form

This application is required to determine your eligibility to receive a reimbursement payment. Please submit this completed form to Benefits@vvc.edu along with proof of premium payments and proof of coverage by the deadline date of March 15th, 2024 for April 2024 payroll payment or by September 15th, 2024 for October 2024 payroll payment. For questions, send email to the same address or call Human Resources at (760) 245-4271 Ext. 2500.

Employee Name: ________________________________ **Date:** ___________________

Semester: _________________

PART A: REIMBURSEMENT ELIGIBILITY (to be completed by employee)

Eligibility (Includes but not limited to):

1. Faculty will have completed at least 40% (.40) load or the equivalent of 224 hours the same semester in which they are applying for reimbursement.
2. HR received approved application for eligibility.
3. Submit request form with proof of coverage document and proof of paid premiums.

I am requesting reimbursement for employee-incurred expenses as follows:

Total Medical Insurance Premium: $ _______________

I certify that the expenses submitted for reimbursement have not already been reimbursed from any other source and any indication to the contrary may disqualify my participation in the Part-time Faculty Reimbursement Program in the future.

Employee Signature: _____________________________ **Date:** ____________________

PART B: ELIGIBILITY VERIFICATION (To be completed by HR Staff only)

Date request was received:

Yes. Request for reimbursement is approved.

All of the required program criteria have been met and verified. Required proof of medical plan enrollment and premium payments are attached to this form.

No. Request for reimbursement is denied.

Reason: ____

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Total amount approved: $ __________________ Date submitted to Payroll: _________________

HR Staff Member Review: _________________________ Date: ______________