



Victor Valley Community College District
Human Resources Department
 18422 Bear Valley Road, Victorville, CA 92395
 (760) 245-4271 Ext. 2500

2025-2026
Part-Time Faculty Health Insurance Pilot Program
Reimbursement Request Form

This application is required to determine your eligibility to receive a reimbursement payment. Please submit the completed form to Benefits@vvc.edu with proof of premium payments and coverage by the deadline dates below.

Reimbursement for premiums incurred between 9/01/25 - 2/28/26 must be submitted by: March 15, 2026, and shall be paid in April 2026.

Reimbursement for premiums incurred between 3/01/26 - 8/31/26 must be submitted by: September 15, 2026, and shall be paid in October 2026.

For questions, send email to the same address or call Human Resources at (760) 245-4271 Ext. 2500.

Employee Name: _____ **Date:** _____
Reimbursement for Semester: ___ Fall 2025 ___ Spring 2026

PART A: Reimbursement Documentation & Certification (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.

Be advised the reimbursement amount cannot exceed the total cost to the employee.

Qualifying Part-time Employees will be reimbursed up to a maximum amount of \$4,000 per semester, or 50% of the medical insurance premiums paid for by part-time employees, whichever is greater.

Reimbursement will be paid by check.

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

Total Amount 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:** _____



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PART B: Reimbursement Determination (To be completed by HR Staff only)

Date request was received: _____ **Semester Load/Hours:** _____

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: _____

Total amount approved: \$ _____ Date submitted to Fiscal: _____

Notes: _____

HR Staff Member Review: _____ Date: _____