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

2024-2025 Part-Time Faculty Health Insurance Pilot Program Reimbursement Request Form

This application is required 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 9/01/24 - 2/28/25 must be submitted by:

- *June 30, 2025, and shall be paid in August 2025.*

Reimbursement for premiums incurred between 3/01/25 - 8/31/25 must be submitted by:

- *September 15, 2025, and shall be paid in October 2025.*

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 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.

Qualifying Part-time Employees will be reimbursed up to a maximum amount of $3500 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:** _____

PART B: Reimbursement Determination (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:_____

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

Notes:_____
_____

HR Staff Member Review: _____ Date: _____