



Part-Time Faculty Attestation of Eligibility for Benefits Coverage Through Senate Bill 551

Section 1 – Employee Information

Last Name	First Name	MI	Employee ID #
Daytime Phone		Email	

Section 2 – Current Benefits

Are you currently a member or a dependent on a PEBB and/or OEGB medical plan?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Section 3 – Current Employment

I am <u>presently</u> employed for [Term] [Year] at the following institutions of higher education:	
<input type="checkbox"/> Blue Mountain Community College	<input type="checkbox"/> Oregon Institute of Technology
<input type="checkbox"/> Central Oregon Community College	<input type="checkbox"/> Oregon State University
<input type="checkbox"/> Chemeketa Community College	<input type="checkbox"/> Portland Community College
<input type="checkbox"/> Clackamas Community College	<input type="checkbox"/> Portland State University
<input type="checkbox"/> Clatsop Community College	<input type="checkbox"/> Rogue Community College
<input type="checkbox"/> Columbia Gorge Community College	<input type="checkbox"/> Southwestern Oregon Community College
<input type="checkbox"/> Eastern Oregon University	<input type="checkbox"/> Southern Oregon University
<input type="checkbox"/> Klamath Community College	<input type="checkbox"/> Tillamook Bay Community College
<input type="checkbox"/> Lane Community College	<input type="checkbox"/> Treasure Valley Community College
<input type="checkbox"/> Linn-Benton Community College	<input type="checkbox"/> Umpqua Community College
<input type="checkbox"/> Mt. Hood Community College	<input type="checkbox"/> University of Oregon
<input type="checkbox"/> Oregon Coast Community College	<input type="checkbox"/> Western Oregon University

Section 4 – Prior Employment

I have worked at the following institutions in the prior 4 terms:	
<input type="checkbox"/> Blue Mountain Community College	<input type="checkbox"/> Oregon Institute of Technology
<input type="checkbox"/> Central Oregon Community College	<input type="checkbox"/> Oregon State University
<input type="checkbox"/> Chemeketa Community College	<input type="checkbox"/> Portland Community College
<input type="checkbox"/> Clackamas Community College	<input type="checkbox"/> Portland State University
<input type="checkbox"/> Clatsop Community College	<input type="checkbox"/> Rogue Community College
<input type="checkbox"/> Columbia Gorge Community College	<input type="checkbox"/> Southwestern Oregon Community College
<input type="checkbox"/> Eastern Oregon University	<input type="checkbox"/> Southern Oregon University
<input type="checkbox"/> Klamath Community College	<input type="checkbox"/> Tillamook Bay Community College
<input type="checkbox"/> Lane Community College	<input type="checkbox"/> Treasure Valley Community College
<input type="checkbox"/> Linn-Benton Community College	<input type="checkbox"/> Umpqua Community College

<input type="checkbox"/> Mt. Hood Community College	<input type="checkbox"/> University of Oregon
<input type="checkbox"/> Oregon Coast Community College	<input type="checkbox"/> Western Oregon University

Section 5: Declaration of Home Institution

I hereby declare my home institution to be:	
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If you need more information prior to declaring a home institution, please contact the Benefits Office(s).

Section 6: Attestation

1. I am a currently a part time faculty member at a public institution of higher education.
2. I am not presently a member or a dependent on a PEBB and/or OEGB medical plan.
3. I have worked at a single Oregon public institution of higher education or in aggregate at multiple Oregon public institutions of higher education during the prior academic year and I was eligible for PERS membership or ORP membership in the prior academic year.
4. I understand I am obligated to declare a home institution and that the home institution must be one at which the part-time faculty member will be receiving pay during the academic term at the time of the application.
5. The home institution will be responsible for determining whether the part-time faculty member is eligible to receive health care benefits; and collecting the 10% employee share of premiums via payroll deduction. Should payroll earnings be insufficient the employee must pay the premiums within 15 calendar days or coverage shall be terminated.
6. I understand each public institution of higher education may have different effective dates, plan offerings and associated cost, with Community College plans being administered by OEGB and Public University Plans being offered by PEBB. Plan research and selection is my sole responsibility. Plan offerings will be limited to those offered by the home institution.
7. It will be my responsibility to provide my declared home public institution of higher education with all information necessary for the institution to determine eligibility within the prescribed time frames.
8. Coverage will end if I am no longer an active employee receiving a paycheck and it will be my sole responsibility to designate a new home institution in a timely manner.
9. Coverage will be subject to plan rules and PEBB or OEGB Administrative Rules.
10. I will inform the home institution immediately of any cancellation of contract or reduction in FTE. If I fail to report a change that makes me ineligible, this may be consider my omission an intentional misrepresentation of a fact material to my enrollment. In that case, my coverage may be terminated retroactively, pursuant to PEBB/OEGB rules.
11. I understand that in addition to this form I must complete and submit an enrollment form for coverage within the required time frame.
12. I understand that if I am qualified and enroll in coverage and my coverage ends, I will be eligible to continue coverage through COBRA.

<input type="checkbox"/>	By signing below, I declare that I have read and attest to each of the statements above. Furthermore, I certify under penalty of perjury that the information I have provided within this application is true and accurate to the best of my knowledge and belief.
Signature	Date

**Part Time Faculty Eligibility Documentation for Benefits Coverage
Senate Bill 551 Coverage**

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Section 2 – Provide information regarding faculty employment in the prior four (4) terms, immediately preceding document date. (Example: for Fall 2021 submission, submit details for Fall 2020, Winter 2021, Spring 2021, and Summer 2021 only). **Attach all backup documentation, which may include, but is not limited to, copies of contracts, offer letters, or documents from the other institution(s), no additional backup documentation is required for work at the home institution detailed below.**

Term/Quarter		Year	
Institution of Higher Education		Position	

Term/Quarter		Year	
Institution of Higher Education		Position	

Term/Quarter		Year	
Institution of Higher Education		Position	

Term/Quarter		Year	
Institution of Higher Education		Position	

<input type="checkbox"/>	By signing below, I certify under penalty of perjury that the information I have provided within this application is true and accurate to the best of my knowledge and belief.		
Signature		Date	