CLEAR FORM

Southern OREGON UNIVERSITY

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 OEBB medical plan?	☐ Yes	☐ No

Section 3 – Current Employment

I am *presently* employed for *[Term]* *[Year]* at the following institutions of higher education:

☐	Blue Mountain Community College	☐	Oregon Institute of Technology
☐	Central Oregon Community College	☐	Oregon State University
☐	Chemeketa Community College	☐	Portland Community College
☐	Clackamas Community College	☐	Portland State University
☐	Clatsop Community College	☐	Rogue Community College
☐	Columbia Gorge Community College	☐	Southwestern Oregon Community College
☐	Eastern Oregon University	☐	Southern Oregon University
☐	Klamath Community College	☐	Tillamook Bay Community College
☐	Lane Community College	☐	Treasure Valley Community College
☐	Linn-Benton Community College	☐	Umpqua Community College
☐	Mt. Hood Community College	☐	University of Oregon
☐	Oregon Coast Community College	☐	Western Oregon University

Section 4 – Prior Employment

I have worked at the following institutions in the prior 4 terms:

☐	Blue Mountain Community College	☐	Oregon Institute of Technology
☐	Central Oregon Community College	☐	Oregon State University
☐	Chemeketa Community College	☐	Portland Community College
☐	Clackamas Community College	☐	Portland State University
☐	Clatsop Community College	☐	Rogue Community College
☐	Columbia Gorge Community College	☐	Southwestern Oregon Community College
☐	Eastern Oregon University	☐	Southern Oregon University
☐	Klamath Community College	☐	Tillamook Bay Community College
☐	Lane Community College	☐	Treasure Valley Community College
☐	Linn-Benton Community College	☐	Umpqua Community College

☐	Mt. Hood Community College	☐	University of Oregon
☐	Oregon Coast Community College	☐	Western Oregon University

Section 5: Declaration of Home Institution

I hereby declare my home institution to be:	

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 OEBB medical plan.
3. I have worked at either at a single Oregon public institution of higher education or in aggregate at multiple Oregon public institutions of higher education during at least three of the four previous academic terms and I will be required to provide documentation related to my work at other public institutions of higher education within the required time frame.
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 OEBB 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 OEBB Administrative Rules.
10. I understand that each institution is independently responsible to assess credit hours to FTE based on each institution's practices.
11. 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/OEBB rules.
12. I understand that in addition to this form I must complete and submit an enrollment form for coverage within the required time frame.
13. I understand that if I am qualified and enroll in coverage and my coverage ends, I will be eligible to continue coverage through COBRA.

☐	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

Section 1 – Employee Information

Last Name	First Name	MI	Employee ID #

Daytime Phone	Email

Section 2 – Provide information regarding faculty employment in the prior four (4) terms, immediately proceeding document date. *(Example: for Fall 2024 submission, submit details for Fall 2023, Winter 2024, Spring 2024, and Summer 2024 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**	

☐	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*