COLLEGE OF MARIN

Fiscal Services

Kentfield Campus
835 College Avenue
Kentfield, CA 94904
415.457.8811

Indian Valley Campus
1800 Ignacio Blvd.
Novato, CA 94949
415.457.8811

Offer of Health Insurance

(*A response is required no later than two weeks from your date of offer)*

As a variable hour, temporary, part-time or seasonal employee of the Marin Community College District (MCCD) for the 2020-2021 school year, you are being given the opportunity to purchase health insurance for you and your eligible children. A summary of the Blue Shield of California: 2-Tier Anchor Bronze Plan is available on our website at http://fiscal.marin.edu/benefits. If you should choose to enroll, you will be responsible for making monthly premium payments.

To request enrollment in this plan, you must submit the following items to the District's benefits office no later than two weeks from your date of offer.

- A completed and signed SISC III Enrollment Form (attached)
- Proof of eligibility for dependent children (birth certificate/adoption paperwork)
- Payment will be setup as a payroll deduction, unless otherwise instructed. If there is not enough payroll to cover the entire premium, a payment by check is required by the 25th of the month prior to the coverage month. If payment is not received by the 5th of the coverage month, your coverage will be terminated.

Make checks payable to: MCCD and returned to the District Benefits Office, 1800 Ignacio Blvd, Novato, CA 94949.

2020-2021 Monthly rates – Blue Shield of California: 2-Tier Anchor Bronze Plan

- Employee only: $ 692.00
- Employee and Children: $ 1,369.00

If your employment status ends at any time during the plan year, your coverage will be terminated the first of the month following and a COBRA Notice will be issued.

If you fail to provide the items required for enrollment, you and your dependent children will not be allowed to enroll until the next eligibility period.

Acknowledgement (Required)

I understand that I am being offered the opportunity to enroll in comprehensive health insurance coverage through my employment with the College of Marin. I understand that as of January 1, 2014, I am required by law to maintain minimum essential health insurance coverage for myself and my dependents, qualify for an exemption from the requirement, or pay a penalty tax. This ACA provision is known as the "individual mandate." Effective in 2019, the individual mandate is effectively repealed, as the penalty tax for noncompliance with the mandate will be reduced to $0.

_____ I authorize payroll deductions for the coverage indicated until further notice. I understand that these rates are subject to change on an annual basis.

_____ I have enclosed a check for the first month's premium. I understand that subsequent monthly payments by check are due in full by the 25th of the month prior to the coverage month and if payment is not received by the 5th of the coverage month, coverage will be terminated.

_____ I decline coverage at this time. Further, I understand unless I experience a qualifying event (for example, marriage, divorce or an increase in hours worked above 130 hours per month), I will not be allowed to enroll in coverage or make changes to my selection until the next eligibility period.

Signature: _____ Date: _____

Print Name: _____ ID#: _____