APPENDIX C (3): APPLICATION FOR HEALTH INSURANCE FUND

To be eligible for the health insurance stipend all of the following must apply:

- Membership in the part-time faculty bargaining unit
- Teaching or employed as a researcher during the term for which assistance is requested
- Insured through an individual policy without health benefits from another source

Name: _____ Employee ID#: _____

Address (w/ city, state, zip): _____

Telephone: _____ E-mail address: _____

Department: _____ Academic term for which you are seeking benefits: _____

What course(s) are you teaching **this term?** (Please list CRNs): _____

What is the name of your current health insurance provider? _____

What is your **monthly** health insurance cost? $ _____

What is your total cost for 3-months (**1 term**)? $ _____

- Please attach a copy of your **monthly billing statement of your monthly premium** (NOTE: PSUFA health insurance stipend can cover *only* the individual member)

I hereby certify that I have no other health insurance available to me either through other employment or through the employment of a family member.

_____ _____

Signature Date

Please return this form one of two ways:

- Email to benefits@psufa.org
- Drop off at the union office, SMSU Rm. 1 (Smith Memorial Student Union, box outside the office)

Please observe the following deadlines for the Health Insurance Fund each term:

- December 1 for benefits for Fall term
- March 1 for benefits for Winter term
- May 1 for benefits for Spring term
- July 1 for benefits for Summer term

If you have any questions, call the PSU Faculty Association at 503-224-3090 or email benefits@psufa.org

Please note that incomplete forms or forms lacking proof of monthly premium cannot be processed

While PSUFA cannot currently cover costs other than members' monthly premiums, we would like to understand more about what our members pay for healthcare each month. What do you estimate your **monthly** healthcare costs to be in addition to your insurance premium? $ _____

(Please give a dollar amount that includes the following: any out-of-pocket costs for dental, optical, mental health, and/or alternative medicine; co-pays and uncovered prescriptions; as well as cost of insurance for spouses or dependents. WE DO NOT REQUIRE PROOF OF THEISE COSTS.)