DELTA DENTAL®
Delta Dental Plan of California

Enrollment — Non Voluntary

Group Name
San Diego Community College District

Delta Group/Division Number
6714 - _ _ _ _

A ENROLLEE (Complete this section for new enrollment or change of status)

Name
Last First Middle Initial

Social Security Number
_____-_____-_____
(Member I.D. Number)

Date Employed
____/____/____
Month Day Year

Action Requested
☐ New enrollment ☐ Reinstatement
☐ COBRA enrollment ☐ Transfer
☐ Change in enrollment ☐ Rehire

Please enroll me in the following:
☑ Delta Dental
☑ Delta Vision

Birthdate
Month Day Year
_____/_____/_____

Sex
☐ Male
☐ Female

Marital Status
☐ Single
☐ Married
☐ Divorced
☐ Separated

Do you have dependent children?
☐ Yes
☐ No

Does your spouse have a dental plan? ☐ Yes ☐ No
If yes, who is covered: ☐ yourself ☐ spouse ☐ dependent children
If Delta Dental, indicate group number: _____

Employee Classification
☐ Certificated ☐ Full-time ☐ Part-time
☐ Classified ☐ Hourly ☐ Retired
☐ Salaried ☐ COBRA

Mailing Address _____ Telephone Number (_____)_____
City _____ State _____ ZIP code _____

FOR DELTA USE ONLY
Effective Date of Coverage
Family Indicator Code

☐ **COBRA Enrollment**
I understand that I may be required by the employer to pay for COBRA benefits

Note: If Dependent is enrolling under own social security number, the original Member's social security number must be supplied.

_____
Benefits previously received under Social Security Number (Member I.D. Number)

Qualifying Date _____/_____/_____
Month Day Year

B Change to Existing Enrollment (Complete all sections that apply)

☐ Name change ☐ Add new dependent ☐ Delete dependent ☐ Address change listed above

Reason for change _____ Effective date of change _____/_____/_____
Month Day Year

C DEPENDENTS (Complete for new enrollment or to add or delete dependents)

Spouse Name Last (if different) / First / Middle Initial	**Add/ Delete**	**Sex** M F	**Birthdate** Month Day Year	**Marriage/Divorce Date** Month Day Year	**Spouse's Social Security Number**
	*	*	____/____/____	____/____/____	

Child Name Last (if different) / First / Middle Initial	**Add/ Delete**	**Sex** M F	**Birthdate** Month Day Year	If Child is 19 years or older (check one) **Full-time Student**	If Child is 19 years or older (check one) **Disabled**	**Child's Social Security Number**
	*	*				
	*	*				
	*	*				
	*	*				

D Signature (Form must be signed to be processed)

I understand there is no contribution required by me for coverage of myself or my dependents. (Exception — See COBRA enrollment) I agree to continue membership in this program during employment and while the program is in force and I agree to comply with the terms of the group contract.

Enrollee Signature _____ Date _____

CALIFORNIA SCHOOLS VEBA

Enrollment Form

Kaiser Permanente & UnitedHealthcare

Welcome to the California Schools VEBA. VEBA purchases and administers your health care benefits. What this means to you is that you get more benefits at a more reasonable cost than if your district purchased benefits on its own. Based on your district, you can enroll yourself and your eligible family members in a health plan through either Kaiser Permanente or UnitedHealthcare.

VEBA is committed to helping you and your family be healthy and stay healthy. To make sure you choose the health plan and doctors that are best for you, we encourage you to research all of the plan benefits that are available to you as well as the medical groups and doctors you use. You can do this by visiting the California Office of the Patient Advocate at www.opa.ca.gov.

WHAT YOU NEED TO KNOW

This form has the following three sections.

Section 1. Employee Enrollment Information *(ALL employees must complete Parts A, B and C of this section)*

- ☐ Fill in all the information requested *(Kaiser Permanente members plan members do NOT have to include a Primary Care Provider (PCP) name or number. UnitedHealthcare (UHC) HMO members can either include a PCP name OR leave the information blank and have UHC assign a PCP based on your zip code.)*
- ☐ Check with your employer to determine if domestic partnership coverage is available
- ☐ You can enroll your eligible dependents up to age 26
- ☐ Proof of permanent disability is required for dependents over age 26

Section 2. Employee Signature Required for Binding Arbitration Agreement

- ☐ All employees must sign the Binding Arbitration agreement as a requirement of the plan you select
- ☐ If you don't sign your health plan's Binding Arbitration agreement your enrollment may be denied

Section 3. UnitedHealthcare (UHC) Information

- ☐ Employees enrolling in a UHC Plan must review and sign the "Release of Medical Information" section

IMPORTANT NOTE: If you enroll in the **UnitedHealthcare Performance HMO Plan:**

- ☐ You and any dependents must ALL enroll in the same network
- ☐ You and each of your dependents will remain in your selected network and HMO plan for the ENTIRE plan year
- ☐ You and your dependents can choose separate Medical Groups as long as they are in the same network
- ☐ You must select a Primary Care Provider—if you do not select a PCP, one will be assigned to you

SECTION 1. ENROLLMENT INFORMATION

A. Your Information *(please print on all sections of form)*

School District Name: San Diego Community College District			Date of Hire:	
Last Name:	First Name:		MI:	☐Male ☐Female ☐Non-Binary
Residence Mailing Address:	City:		State:	Zip Code:
Home Telephone:	Work Telephone:		Birth Date *(mm-dd-yy)*:	
Social Security No. *(SSN)*:	Marital Status: ☐Single ☐Married ☐Divorced ☐Widow ☐Domestic Partner			
PCP Name (UHC Members):	PCP Number (UHC Members):		Are You an Existing Patient? ☐Yes ☐No	
Are you currently on COBRA? ☐Yes ☐No If "Yes," COBRA Qualifying Event & Effective Date____________________			Your Email Address:	

D. Employer to Complete This Section

Group #/Plan Code:
Requested Effective Date:
Source of Enrollment/Change Event: ☐Open Enrollment ☐Employee Status Change ☐Dependent Status Change ☐New Hire ☐Rehire ☐Termination ☐QMCSO (*Qualified Medical Child Support Order)* Enrollment Event Date:
Employee Class:
☐Active ☐Retired ☐Leave ☐COBRA

B. Select Your Coverage

Enrollees	Health Plan				
☐Self ☐Self + 1 ☐Self + family	☐ **Kaiser Permanente HMO $0**	☐ **UnitedHealthcare (UHC) Performance HMO - Network 1**	☐ **UHC Alliance HMO $20/30**	☐ **UHC Harmony HMO $10**	☐ **UHC Journey HMO with HRA**

C. Dependent Information *(attach additional sheets if necessary)*

☐Add ☐Delete ☐Change	Spouse/Domestic Partner Name	☐M ☐F ☐NB	Address *(if different from yours)*	Birth Date *(mm-dd-yy)*	SSN:	PCP Name: ____________ PCP No.:____________ Existing Patient? ☐Yes ☐No
☐Add ☐Delete ☐Change	Dependent Name *(Last, First, MI)*	☐M ☐F ☐NB	Address *(if different from yours)*	Birth Date *(mm-dd-yy)*	SSN:	PCP Name: ____________ PCP No.:____________ Existing Patient? ☐Yes ☐No
☐Add ☐Delete ☐Change	Dependent Name *(Last, First, MI)*	☐M ☐F ☐NB	Address *(if different from yours)*	Birth Date *(mm-dd-yy)*	SSN:	PCP Name: ____________ PCP No.:____________ Existing Patient? ☐Yes ☐No
☐Add ☐Delete ☐Change	Dependent Name *(Last, First, MI)*	☐M ☐F ☐NB	Address *(if different from yours)*	Birth Date *(mm-dd-yy)*	SSN:	PCP Name: ____________ PCP No.:____________ Existing Patient? ☐Yes ☐No
☐Add ☐Delete ☐Change	Dependent Name *(Last, First, MI)*	☐M ☐F ☐NB	Address *(if different from yours)*	Birth Date *(mm-dd-yy)*	SSN:	PCP Name: ____________ PCP No.:____________ Existing Patient? ☐Yes ☐No

SECTION 2. EMPLOYEE SIGNATURE REQUIRED FOR BINDING ARBITRATION AGREEMENT

Based on the health plan you enroll in, you must sign the plan's Binding Arbitration agreement for your enrollment to be effective.

- Sign **A** below for **Kaiser plan**
- Sign **B** below for **UnitedHealthcare plan**

A. Kaiser Foundation Health Plan Binding Arbitration Agreement *(Read and sign this section ONLY if you enroll in a Kaiser Permanente Plan)*

Kaiser Foundation Health Plan Arbitration Agreement

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage.

☐ *By checking this box, I am indicating that I have carefully read the above "Binding Arbitration" agreement and agree to its terms.*

Employee Signature required for Kaiser Permanente Plan	**Employee Name** (please print)	**Date** (month/day/year)

* Disputes arising from fully-insured Kaiser Permanente Insurance Company (KPIC) coverage are not subject to binding arbitration 1) the Preferred Provider Organization (PPO) and the Out-of Network portion of the Point of Service (POS) plans; 2) Preferred Provider Organization (PPO) plans; 3) Out of Area Indemnity (OOA) plans; and 4) KPIC Dental plans.

B. UnitedHealthcare Plan Members Binding Arbitration Agreement *(Read and sign this section ONLY if you enroll in a UnitedHealthcare Plan)*

UnitedHealthcare Binding Arbitration Agreement

I AGREE AND UNDERSTAND THAT ANY AND ALL DISPUTES, INCLUDING CLAIMS RELATING TO THE DELIVERY OF SERVICES UNDER THE PLAN AND CLAIMS OF MEDICAL MALPRACTICE (THAT IS, AS TO WHETHER ANY MEDICAL SERVICES RENDERED UNDER THE HEALTH PLAN WERE UNNECESSARY OR UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED), EXCEPT FOR CLAIMS SUBJECT TO ERISA, BETWEEN MYSELF AND MY DEPENDENTS ENROLLED IN THE PLAN (INCLUDING ANY HEIRS OR ASSIGNS) AND UNITEDHEALTHCARE OF CALIFORNIA, UNITEDHEALTHCARE OR ANY OF ITS PARENTS, SUBSIDIARIES OR AFFILIATES, SHALL BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION. ANY SUCH DISPUTE WILL NOT BE RESOLVED BY A LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS THE FEDERAL ARBITRATION ACT PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. ALL PARTIES TO THIS AGREEMENT ARE GIVING UP THEIR CONSTITUTIONAL RIGHTS TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION.

YOUR SIGNATURE

☐ *By checking this box, I am indicating that I have carefully read the above "Binding Arbitration" agreement and agree to its terms.*

Employee Signature	**Employee Name** (please print)	**Date** (month/day/year)

SECTION 3. UNITEDHEALTHCARE PLAN *(UHC plan members must sign "Authorization to Release Medical Information" below)*

HIV Disclaimer
"California law prohibits an HIV test from being required or used by health care service plans and insurance companies as a condition of obtaining coverage."

Legal Entities Disclaimer
Health plan coverage provided by or through UnitedHealthcare Insurance Company and UnitedHealthcare of California. Administrative services provided by UnitedHealthcare Insurance Company, United HeathCare Services, Inc., PacifiCare Health Plan Administrators, Inc., Prescription Solutions or Optum Health Care Solutions, Inc. Behavioral health products are provided by U.S. Behavioral Health Plan, California (USBHPC) or United Behavioral Health (UBH).

Authorization to Release Medical Information
I authorize UnitedHealthCare Insurance Company and its affiliates ("UnitedHealthcare and Affiliates") to obtain, use and disclose my medical, claim or benefit records, including any individually identifiable health information contained in these records. I understand these records may contain information created by other persons or entities (including health care providers) as well as information regarding the use of drug, alcohol, HIV/AIDS, mental health (other than psychotherapy notes), sexually transmitted disease and reproductive health services. I authorize any health care provider, pharmacy benefit manager, other insurer or reinsurer, hospital, clinic or other medical facility, health care clearinghouse, and any of their affiliates, representatives or business associates, who may be in possession of my confidential health information, to disclose my information to UnitedHealthcare and Affiliates. I understand the purpose of the disclosure and use of my information is to allow UnitedHealthcare and Affiliates to make decisions regarding eligibility, enrollment and risk rating. I understand this authorization is voluntary and I may refuse to sign the authorization. My refusal may, however, affect my ability to enroll in the health plan or receive benefits, if permitted by law. I understand I may revoke this authorization at any time by notifying my UnitedHealthcare and Affiliates representative in writing, except to the extent that action has already been taken in reliance on this authorization. As required by HIPAA, UnitedHealthcare and Affiliates also request that I acknowledge the following, which I do: I understand that information I authorize a person or entity to obtain and use may be re-disclosed (with the exception of HIV/AIDS health information) and no longer protected by federal privacy regulations except as prohibited by state law. This authorization, unless revoked earlier, expires 30 months after the date it is signed. I understand that I am completing a health application and that each response must be complete and accurate. I (we) request the indicated group medical coverage for myself and, if the plan provides, for my dependents. I authorize any required premium contributions to be deducted from earnings. I (we) have not given the agent or any other persons any health information not included on the Request for Coverage. I (we) understand that the HMO/insurance company(ies) is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this Request for Coverage and any attachments. UnitedHealthcare is only seeking to collect information about the current health status of those persons listed on the application. You should not include any genetic information. Please do not include any family medical history information related to genetic services or genetic diseases for which you believe you or your dependents may be at risk.

☐ *By checking this box, I am indicating that I have carefully read the above "Authorization to Release Medical Information" and agree to its terms.*

Employee Signature	**Employee Name** (please print)	**Date** (month/day/year)

Beneficiary Designation

Securian Life Insurance Company
Minnesota Life Insurance Company

Administered by Ochs, Inc.
Group Customer Service • 400 Robert Street North, Suite 1880, St. Paul, MN 55101-2025

INSTRUCTIONS

1. Clearly print or type the information.
2. Sign and date the completed form.
3. Return to:

   San Diego Community College District
   People, Culture, and Technology Services – Benefits Office
   3375 Camino del Rio South, Suite 380
   San Diego, CA 92108-3883

   YOUR EMPLOYER STORES THE BENEFICIARY DESIGNATIONS

GENERAL BENEFICIARY INFORMATION

- Completing this Beneficiary Designation form will revoke all current beneficiary designations.
- The same person(s) cannot be named as both a primary and contingent beneficiary.
- If you need more space, attach an additional sheet of paper with all of the information required. Be sure to sign and date this additional information page.
- To receive a death benefit, a beneficiary must survive the insured. If the named beneficiary does not survive the insured, that beneficiary's portion shall be equally distributed to the remaining beneficiaries within that category.
- **Primary Beneficiary:** This is the individual(s), trust, charity, or estate that you want to receive the insurance benefit. You can divide the insurance proceeds between primary beneficiaries. The total shares must equal 100%.
- **Contingent Beneficiary:** If all the primary beneficiary(ies) are no longer living, eligible, or able to receive the benefits, it will be paid to the contingent beneficiary(ies) designated. You can divide the insurance proceeds between your named contingent beneficiaries. The total shares must equal 100%.
- **Naming Minor Children:** You may name your children (by name) directly, or to a trust. Minors cannot directly receive life insurance proceeds; however, they may be paid to a court-appointed guardian or held until the minor child is legal age.
- **Trust:** Provide the trust name, effective date and tax ID or Social Security number (if applicable) - i.e., "John Smith Trust dated 01/01/20xx."
- **Charity:** Provide the full name, address, tax ID number.

CONTINUE ON TO NEXT PAGE

Client stores the beneficiary designations

Beneficiary Designation

Securian Life Insurance Company • Minnesota Life Insurance Company

Employer name	Policy number
San Diego Community College District	34625
Insured's name (first, middle initial, last)	ID (or last four of SSN)
Address (street, city, state, zip)	Email address
Insured's date of birth / Policyowner (if different than insured)	Policyowner's phone number

This designation applies to all coverages.

PRIMARY BENEFICIARY(IES) - The person or persons named will receive the benefit.

Beneficiary full name/trust name	Date of birth/trust date	Tax ID (SSN or EIN)	Share %
Address (street, city, state, zip) and phone number		Relationship to insured	
Beneficiary full name	Date of birth	Tax ID (SSN)	Share %
Address (street, city, state, zip) and phone number		Relationship to insured	
Beneficiary full name	Date of birth	Tax ID (SSN)	Share %
Address (street, city, state, zip) and phone number		Relationship to insured	
Beneficiary full name	Date of birth	Tax ID (SSN)	Share %
Address (street, city, state, zip) and phone number		Relationship to insured	

Total Primary Shares Must Equal 100%

CONTINGENT BENEFICIARY(IES) - Receives a benefit ONLY if all primary beneficiaries are no longer living.

Beneficiary full name/trust name	Date of birth/trust date	Tax ID (SSN or EIN)	Share %
Address (street, city, state, zip) and phone number		Relationship to insured	
Beneficiary full name	Date of birth	Tax ID (SSN)	Share %
Address (street, city, state, zip) and phone number		Relationship to insured	
Beneficiary full name	Date of birth	Tax ID (SSN)	Share %
Address (street, city, state, zip) and phone number		Relationship to insured	

Total Contingent Shares Must Equal 100%

SIGNATURE REQUIRED - This beneficiary form revokes all prior designations.

Insured or policyowner's penned signature	Date
X	

Community Property State Consent for current and former residents of Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, or Wisconsin. If you are married and live in, or previously lived in, a community property state and name someone other than your spouse as beneficiary, you may have your spouse sign below to waive his or her rights to any community property interest in the benefit. You should consult with a qualified tax advisor and/or seek legal advice if you have any questions in connection with the Beneficiary Designation.

As the Insured's spouse, I do hereby consent to the beneficiary designation(s) indicated on this form and waive any right that I may have to the proceeds of such insurance under applicable community property laws. My spouse may withdraw this designation at any time but may not designate a different primary beneficiary without my consent.

Signature of spouse	Please print spouse name clearly	Date signed
X		

SAN DIEGO COMMUNITY COLLEGE DISTRICT
HUMAN RESOURCES, DISTRICT OFFICE
3375 CAMINO DEL RIO SOUTH
SAN DIEGO, CA 92108

IMPORTANT

TO: Employees Eligible for Benefits

FROM: Benefits Office

SUBJECT: Documents for Eligible Dependents

The San Diego Community College District requires that documentation, such as certified copies of marriage certificate/license and birth certificate(s), proving the eligibility of dependents enrolled in medical plans be submitted to the Benefits Office at the time of enrollment.

This is to certify that I have read and understand the requirements to enroll my dependent(s) and that failure to provide the Benefits Office with required documentation may result in the termination of medical, dental, and vision benefits for my dependents.

DATE_____SIGNATURE_____

PRINT NAME_____ JOB TITLE_____

_____-_____-_____ WORK LOCATION_____
Social Security Number

FOR OFFICIAL USE ONLY

DOCUMENTS NOT SUBMITTED _____

_____

Second Notice_____ Final Notice_____

Public Service Loan Forgiveness (PSLF) Program

What is the Public Service Loan Forgiveness Program?

Congress created the Public Service Loan Forgiveness Program (PSLF) in 2007 to encourage individuals to enter and continue to work full time in public service jobs. Under this program, borrowers may qualify for forgiveness of the remaining balance due on their eligible federal student loans after they have made 120 payments on those loans under certain repayment plans while employed full time for at least 10 years by certain public service employers.

What loans qualify for forgiveness?

Only loans received under the William D. Ford Federal Direct Loan (Direct Loan) Program are eligible for PSLF. Loans received under the Federal Family Education Loan (FFEL) Program, the Perkins Loan Program, or any other student loan programs are not eligible for PSLF.

If you have FFEL and/or Perkins loans, you may consolidate them into a Direct Consolidation Loan to take advantage of PSLF. However, only payments made on the new Direct Consolidation Loan will count toward the 120-month payment requirement for PSLF. Payments made on your FFEL or Perkins loans, even if made under a qualifying repayment plan, do not count as qualifying PSLF payments.

What payment plans qualify for forgiveness?

Payments made under one or more of the following Direct Loan Program repayment plans count toward the 120-month payment requirement provided all other criteria are met:

- Income Based Repayment (IBR) Plan
- Income Contingent Repayment (ICR) Plan
- 10-Year Standard Repayment Plan
- Any other repayment plan where the monthly payment amount equals or exceeds what would be paid under a 10-Year Standard Repayment Plan.

You must have made 120 separate monthly payments after October 1, 2007, on the Direct Loan Program loans for which forgiveness is requested. Earlier payments do not count toward meeting this requirement. Each of the 120 monthly payments must be made for the full scheduled installment amount within 15 days of the due date.

IMPORTANT NOTE: *The PSLF Program provides for forgiveness of the remaining balance of a borrower's eligible loans after the borrower has made 120 qualifying payments on those loans. In general, only borrowers who are making reduced monthly payments through the Direct Loan Income Contingent or Income Based repayment plans will have a remaining balance after making 120 payments on a loan. Since the 10-Year Standard Repayment Plan requires you to fully pay off your loan within ten years (120 monthly payments), you will not have any remaining loan balance to be forgiven if you make all of your 120 required payments under a 10-Year Standard Repayment Plan. The 10-year Standard Plan is included as an eligible repayment plan for PSLF purposes so that borrowers may receive credit toward the required 120 PSLF payments for payments they may have made under this plan before switching to either IBR or ICR plans or after leaving IBR or ICR plans.*

What kinds of employment qualify?

Qualifying employment is any full time employment (generally, as determined by the employer) with a federal, state, or local government agency, entity, or organization or a non-profit organization that has been designated as tax-exempt by the Internal Revenue Service. The type or nature of employment with the organization does not matter for PSLF purposes. Additionally, the type of services that these public service organizations provide does not matter for PSLF purposes.

When may I apply?

Borrowers may not apply for loan forgiveness until after they have made 120 separate monthly qualifying loan payments while being employed full time at a qualifying public service organization, and only payments made after October 1, 2007, count toward the required 120 separate, monthly payments. The earliest date that any borrower will be eligible to apply for PSLF is October 2017.

What are the application requirements?

Prospective applicants must meet and maintain the following requirements for loan forgiveness under the PSLF Program:

- You must not be in default on the loans for which forgiveness is requested.
- You must be employed full time by a public service organization when making each of the required 120 monthly loan payments at the time you apply for loan forgiveness; and at the time the remaining balance on your eligible loans is forgiven.

How can I track my progress?

The U.S. Department of Education has created the Employment Certification for Public Service Loan Forgiveness form www.studentaid.ed.gov/publicservice and a process to help you monitor your progress toward making the 120 qualifying payments necessary to apply for PSLF. You should complete the form, including your employer's certification of employment, and submit it to FedLoan Servicing, the PSLF servicer, at the address listed in Section 6 of the Employment Certification form.

The form allows you to get your employer's certification of employment while you are still employed at that organization or shortly after leaving. The process allows you to receive confirmation of qualifying employment and Direct Loan payment eligibility. You may also submit the form less frequently than annually to cover more than one year's employment or for more than one employer.

Is the Employment Certification for Public Service Loan Forgiveness form required?

While use of the form and process is not required, it will help you keep track of your progress toward meeting the PSLF eligibility requirements. If you do not periodically submit the form, you will still be required to submit a form for each qualifying employer at the time you apply for forgiveness and when forgiveness is granted.

Frequently Asked Questions

Q1: If an individual has been making payments since 'before' 2007 (e.g. 2005) can she/he count those payments toward the 120 required payments?

A1: No. Only payments made on or after October 1, 2007, when the program began may be counted towards the required 120 payments.

Scenario 1: Bob started making payments on his student loan in October 2005 while working for Metropolitan Life Insurance Company. Bob was hired by FSIS in October 2009. He made 48 payments while employed with Metropolitan but none of those payments will count toward the PSLF. Bob's payments toward the 120 required payments will start in October 2009 when his employment with FSIS, a public service agency, began.

Q2: If an individual, previously employed by a non-qualifying employer has been making monthly payments since October 2007 and started working for FSIS in January 2008, can she/he get credit for those payments made before employment with FSIS?

A2: No. The PSLF requires that the individual be employed with a public service agency in order to apply and qualify for PSLF. However, if the employee transferred from another federal agency, then the payments would qualify for PSLF.

Scenario 2: Jane started making her required monthly payments in October 2007 while directly employed at Perdue Farms. In January 2008 she began her employment with FSIS. Jane's payments toward the 120 required payments will start in January 2008 when her employment with FSIS, a public service agency, began.

Q3: Must the 120 separate, monthly required payments for PSLF be consecutive?

A3: No. The payments do not have to be consecutive payments; but you must be employed by a qualifying public service organization at the time you make each of the 120 qualifying payments.

Scenario 3: Paul made monthly payments from January 2009 to December 2009 while working at FSIS. He resigned for one year but continued making monthly payments. In January 2011, he was re-employed by FSIS. Although Paul made payments during 2010, they do not count toward PSLF because he was not employed by a qualified public service employer.

For more information on the Public Student Loan Forgiveness Program, please visit:
http://studentaid.ed.gov/PORTALSWebApp/students/english/PSF.jsp

PUBLIC SERVICE LOAN FORGIVENESS (PSLF): APPLICATION FOR FORGIVENESS

William D. Ford Federal Direct Loan (Direct Loan) Program

OMB No. 1845-0110
Form Approved
Exp. Date 5/31/2020
PSFAP - XBCR

PSLF APP

WARNING: Any person who knowingly makes a false statement or misrepresentation on this form or on any accompanying document is subject to penalties that may include fines, imprisonment, or both, under the U.S. Criminal Code and 20 U.S.C. 1097.

SECTION 1: BORROWER INFORMATION

Please enter or correct the following information.

☐ **Check this box if any of your information has changed.**

SSN _____

☐ Date of Birth _____

Name _____

Address _____

City _____ State _____ Zip Code _____

Telephone - Primary _____

Telephone - Alternate _____

Email (Optional) _____

Before signing, carefully read the entire form. For more information on PSLF, visit **StudentAid.gov/publicservice**. Use this form only if you **(1)** have Direct Loans, **(2)** made 120 qualifying payments on the Direct Loans for which you are seeking forgiveness, and **(3)** worked, and continue to work, full-time at a qualifying employer when you made the qualifying payments. If the employment certified in Sections 3 and 4 of this application does not cover all 120 qualifying payments, you must submit a copy of Section 3 and 4 (page 2) for each qualifying employer that covers the rest of your qualifying payments.

SECTION 2: BORROWER REQUEST, UNDERSTANDINGS, CERTIFICATION, AND AUTHORIZATION

I request (1) that the U.S. Department of Education (the Department) forgive the remaining balance of my Direct Loans and **(2)** if I submit employment certification covering 10 years of qualifying employment after October 1, 2007, a forbearance on my Direct Loans while the Department determines my eligibility for forgiveness, unless I indicate otherwise below.

☐ By checking this box, I am indicating that I **do not want a forbearance** while my application is being processed.

I understand that:

1. To qualify for PSLF, I must have made 120 qualifying payments on my Direct Loans while employed full-time by a qualifying employer or employers. Neither the 120 qualifying payments nor employment have to be consecutive.
2. To qualify for PSLF, I must be employed full-time by a qualifying employer when I apply for and receive PSLF.
3. By submitting this form, my student loans held by the Department will be transferred to FedLoan Servicing.
4. If the Department determines that I appear to be eligible for forgiveness, the Department may contact my employer before granting forgiveness to ensure that I continue to work for the employer.
5. If I am eligible for forgiveness, the amount forgiven will be the principal and interest that was due on my eligible Direct Loans when I made my final qualifying payment. Any amount that I pay on those loans after I have made my final qualifying payment will be treated as an overpayment. I must continue to make payments on any of my other loans.
6. If I am not eligible for forgiveness, I will be notified of the determination and why it was made, my forbearance will end, and unpaid interest may be capitalized (added to my loan's principal balance).

I certify that all of the information I have provided on this form and in any accompanying document is true, complete, and correct to the best of my knowledge and belief and that if I cease to be employed by a qualifying employer after I submit this application, but before forgiveness is granted, I will notify the Department (see Section 7) immediately.

I authorize my employer or other entity having records about the employment that is the basis of my request to make information from those records available to the U. S. Department of Education (the Department) or its agents or contractors.

☐ Check this box if you cannot obtain certification from your employer because the organization is closed or because the organization has refused to certify your employment. The Department will follow up to assist you in getting documentation of your employment. **Complete Section 3, but do not complete Section 4.**

Borrower's Signature _____ **Date** _____

Borrower Name: _____ Borrower SSN: |__|__|__|-|__|__|-|__|__|__|__|

SECTION 3: CERTIFICATION OF EMPLOYMENT

See Section 3 of the accompanying *Instructions for Completing Employment Certification for Public Service Loan Forgiveness* for detailed information on completing this section.
These *Instructions* are also located at www.studentaid.ed.gov/publicservice

An authorized official (see Section 5) of the public service organization at which the borrower is/was employed must complete this section.

Instructions for Authorized Official:

- Complete this form only if you are an authorized official of the public service organization at which the borrower identified in Section 1 is/was employed or, if the borrower is/was a full-time AmeriCorps or Peace Corps volunteer, an authorized official of AmeriCorps or the Peace Corps.
- Read the definitions in Section 5 before completing this form.
- Type or print using blue or black ink. All fields must be completed if applicable. Your signature date must include month, day, and year (MM-DD-YYYY).
- Provide all requested information for Items 1, 2, and 3 below. Complete the employer's certification at the bottom of this page. The Employment Certification form cannot be processed if the information requested in this section is missing.
- If you make any changes to the information you provide in this section, you must initial each change.

Please return the completed form to the borrower. The U.S. Department of Education or the PSLF servicer may contact you for additional information or documentation.

Instructions for Borrower when there is no Authorized Official:

- ☐ Check this box if you are unable to obtain certification from an authorized official, for example, because the organization no longer exists. Provide all requested information for Items 1, 2, and 3 below. For Item 1, list the organization's address from when you worked there, and consult your W2 records for the EIN. The Department will require you to submit additional evidence of your qualifying employment. Do not submit supporting documents until requested to do so.

1. Information about the public service organization at which the borrower is/was employed.

_____ |__|__| - |__|__|__|__|__|__|__|
Public Service Organization Name — Federally Assigned Employer ID# (EIN)

_____
Public Service Organization Address

2. Borrower's Employment Status.

(a) Dates of employment: (MM-DD-YYYY) Start: |__|__| - |__|__| - |__|__|__|__| End: |__|__| - |__|__| - |__|__|__|__| (If the borrower is still employed, put today's date)

(b) Borrower's employment status at your organization:

☐ **Full-Time** Average number of hours per week: _____

☐ **Part-Time** Average number of hours per week: _____

For purposes of eligibility for PSLF, **full-time** employment is defined as:
(1) Working in qualifying employment in one or more jobs for the greater of:
(A) An annual average of at least 30 hours per week or, for a contractual or employment period of at least 8 months, an average of 30 hours per week; or
(B) Unless the qualifying employment is with two or more employers, the number of hours the employer considers full-time.
(2) Vacation or leave time provided by the employer or leave taken for a condition that is a qualifying reason for leave under the Family and Medical Leave Act of 1993, 29 U.S.C. 2612(a)(1) and (3) is equivalent to hours worked in qualifying employment.
NOTE: A full-time AmeriCorps or Peace Corps volunteer is considered a full-time employee for eligibility purposes for PSLF.

3. Type of Public Service Organization, in accordance with the definition in Section 5 (check one):

(a) ☐ A **government organization** (including a Federal, State, local or Tribal organization, agency or entity; a public child or family service agency; or a Tribal college or university);

(b) ☐ A **non-profit, tax-exempt organization under Section 501(c)(3) of the Internal Revenue Code**;

(c) ☐ A **private, non-profit organization** (that is not a labor union or a partisan political organization) that provides at least one of the following public services (check all that apply):
- ☐ Emergency management,
- ☐ Military service,
- ☐ Public safety,
- ☐ Law enforcement,
- ☐ Public interest law services,
- ☐ Early childhood education (including licensed or regulated child care, Head Start, and State-funded pre-kindergarten),
- ☐ Public service for individuals with disabilities and the elderly,
- ☐ Public health (including nurses, nurse practitioners, nurses in a clinical setting, and full-time professionals engaged in health care practitioner occupations and health support occupations, as such terms are defined by the Bureau of Labor Statistics),
- ☐ Public education,
- ☐ Public library services,
- ☐ School library services, or
- ☐ Other school-based services.

NOTE as to categories (b) and (c): For purposes of the full-time requirement (Section 3, Item 2.(b) above), a borrower's qualifying employment does not include time spent on job duties that are related to religious instruction, worship services, or any form of proselytizing.

I certify that the borrower identified in Section 1 above is/was employed at a public service organization, as indicated above, or is/was serving in an AmeriCorps or Peace Corps position (in accordance with the definitions of these terms in Section 5) during the period identified in Item 2(a) of this section.

_____ _____
Authorized Official's Name (Printed) — Authorized Official's Title

_____ (_____) _____
Authorized Official's Signature — Authorized Official's Telephone — Today's Date (MM-DD-YYYY)

SECTION 4: ELIGIBILITY REQUIREMENTS / TERMS AND CONDITIONS FOR PUBLIC SERVICE LOAN FORGIVENESS

You may obtain loan forgiveness under this program if:

(1) You are not in default on the loan(s) for which forgiveness is requested.

(2) Except as provided below for AmeriCorps and Peace Corps volunteers, you have made 120 separate, on-time, qualifying monthly payments after October 1, 2007, on the Direct Loan(s) for which you are requesting forgiveness under one or more of the following repayment plans—

- The Income-Based Repayment (IBR) Plan;
- The Income Contingent Repayment (ICR) Plan;
- The 10-Year Standard Repayment Plan* (Standard Repayment Plan with a maximum 10-year repayment period); or
- Any other Direct Loan repayment plan, but only payments that are at least equal to the monthly payment amount that would be required under the Standard Repayment Plan with a 10-year repayment period may be counted toward the required 120 payments.

In addition, each of the required 120 separate, qualifying monthly payments must have been made on time (no more than 15 days after the scheduled due date) and for the full scheduled installment amount.

* **IMPORTANT:** The Standard Repayment Plan for Direct Consolidation Loans entered on or after July 1, 2006 have varying repayment terms based on the loan amount. For purposes of qualifying for Public Service Loan Forgiveness, monthly payments you make under the Standard Repayment Plan on a Direct Consolidation Loan are only qualifying payments if made under the 10-year repayment term.

Note for AmeriCorps/Peace Corps volunteers: If you were an AmeriCorps or Peace Corps volunteer, you may receive credit for making qualifying payments if you make a lump sum payment on an eligible loan for which you are seeking forgiveness by using all or part of a Segal Education Award received after a year of AmeriCorps service, or by using all or part of a Peace Corps transition payment (if the payment is made within 6 months after you leave the Peace Corps). The Department will consider the lump sum payment you have made as the equivalent of qualifying payments equal to the lesser of:

(1) The number of payments resulting after dividing the amount of the lump sum payment by the monthly payment amount you would have made under one of the qualifying repayment plans listed above; or

(2) Twelve payments.

Peace Corps volunteers making an eligible lump sum payment must do so within 6 months of the End Date, as reported in Section 3 by the authorized official.

(3) You were/are employed full time by one or more public service organizations or serving in a full-time AmeriCorps or Peace Corps position at the time you made each of the required 120 qualifying monthly payments, at the time you apply for loan forgiveness, and at the time loan forgiveness is granted.

NOTE: You are not permitted to apply the same period of service to receive a benefit under the PSLF Program and the Teacher Loan Forgiveness, Service in Areas of National Need, and Civil Legal Assistance Attorney Student Loan Repayment Programs.

You may not apply for PSLF until after you have met the eligibility requirements listed above. Since only qualifying payments made after October 1, 2007, while employed at a qualifying public service organization may be counted toward the required 120 payments, and borrowers may not apply for loan forgiveness until after they have made all 120 payments, the earliest date that any borrower will be eligible to apply for and receive loan forgiveness is October 2017. A PSLF Application will be made available to the public before October 2017.

SECTION 5: DEFINITIONS

Eligible Loans

Loans that are eligible for Public Service Loan Forgiveness are:

- Federal Direct Stafford/Ford Loans (Direct Subsidized Loans)
- Federal Direct Unsubsidized Stafford/Ford Loans (Direct Unsubsidized Loans)
- Federal Direct PLUS Loans (Direct PLUS Loans)
- Federal Direct Consolidation Loans (Direct Consolidation Loans).

Loans that are in default are not eligible for forgiveness.

Note: Federal Family Education Loan (FFEL) Program loans, Federal Perkins Loans, and certain Health Professions and Nursing Loans may be consolidated into a Direct Consolidation Loan. However, payments made on these loans prior to consolidation into the Direct Loan Program are not qualifying payments and are not counted toward the required 120 payments for PSLF.

Qualifying Payments

- Separate, on-time, full monthly payments made after October 1, 2007 under a qualifying Direct Loan repayment plan. A payment is considered on-time if it is made for the full scheduled installment amount no more than 15 days after the due date for the payment.
- Qualifying Direct Loan repayment plans are:
  - The IBR Plan;
  - The ICR Plan;
  - The 10-Year Standard Repayment Plan (Standard Repayment Plan with a maximum 10-year repayment period); and
  - Any other Direct Loan repayment plan, but only payments that are at least equal to the monthly payment amount that would be required under the Standard Repayment Plan with a 10-year repayment period may be counted toward the required 120 monthly payments.

Qualifying Employment

- **AmeriCorps position** means a position approved by the Corporation for National and Community Service under Section 123 of the National and Community Service Act of 1990 (42 U.S.C. 12573).
- An **authorized official** is an official of a public service organization (including AmeriCorps or the Peace Corps) who has access to the borrower's employment or service records and is authorized by the public service organization to certify the employment status of the organization's employees or former employees, or the service of AmeriCorps or Peace Corps volunteers.
- An **employee** means an individual who is hired and paid by a public service organization.
- **Full-time** means working in qualifying employment in one or more jobs for the greater of:
  - An annual average of at least 30 hours per week or, for a contractual or employment period of at least 8 months, an average of 30 hours per week; or
  - Unless the qualifying employment is with two or more employers, the number of hours the employer considers full time.

  Vacation or leave time provided by the employer or leave taken for a condition that is a qualifying reason for leave under the Family and Medical Leave Act of 1993, 29, U.S.C. 2612(a)(1) and (3) is equivalent to hours worked in qualifying employment.
- **Government employee** means an individual who is employed by a local, State, Federal, or Tribal government, but does not include a member of the U.S. Congress.
- **Law enforcement** means service performed by an employee of a public service organization that is publicly funded and whose principal activities pertain to crime prevention, control or reduction of crime, or the enforcement of criminal law.
- **Military service** for uniformed members of U.S. Armed Forces or the National Guard means "active duty" service or "full-time National Guard duty" as defined in Section 101(d)(1) and (d)(5) of Title 10 in the United States Code, but does not include active duty for training or attendance at a service

school. For civilians, military service means service on behalf of the U.S. Armed Forces or the National Guard performed by an employee of a public service organization.

- **Peace Corps** position means a full-time assignment under the Peace Corps Act as provided for under 22 U.S.C. 2504.
- **Public interest law** refers to legal services provided by a public service organization that are funded in whole or in part by a local, State, Federal, or Tribal government.
- A **public service organization** is:
  - A Federal, State, local or Tribal government organization, agency or entity;
  - A public child or family service agency;
  - A non-profit organization under Section 501(c)(3) of the Internal Revenue Code that is exempt from taxation under Section 501(a) of the Internal Revenue Code;
  - A Tribal college or university; or
  - A private organization (that is not a labor union or a partisan political organization) that provides at least one of the following public services:
    - emergency management,
    - military service,
    - public safety,
    - law enforcement,
    - public interest law services,
    - early childhood education (including licensed or regulated child care, Head Start, and State funded pre-kindergarten),
    - public service for individuals with disabilities and the elderly,
    - public health (including nurses, nurse practitioners, nurses in a clinical setting, and full-time professionals engaged in health care practitioner occupations and health support occupations, as such terms are defined by the Bureau of Labor Statistics),
    - public education,
    - public library services,
    - school library services, or
    - other school-based services.

NOTE: For purposes of the full-time requirement (Section 3, Item 2.(b) above), an individual borrower's qualifying employment with a Section 501(c)(3) non-profit or other private public service organization does not include time spent on job duties that are related to religious instruction, worship services, or any form of proselytizing.

SECTION 6: WHERE TO SEND THE COMPLETED FORM

Send the completed Employment Certification to:

U.S. Department of Education
FedLoan Servicing
P.O. Box 69184
Harrisburg, PA 17106-9184
Or Fax to: 717-720-1628

If you need help completing this form, call: 855-265-4038
If you use a telecommunications device for the deaf (TDD), call: 800-722-8189

Web site: www.MyFedLoan.org

SECTION 7: IMPORTANT NOTICES

Privacy Act Notice. The Privacy Act of 1974 (5 U.S.C. 552a) requires that the following notice be provided to you:

The authorities for collecting the requested information from and about you are §421 et seq., §451 et seq.,§461 et seq., and §420L et seq. of the Higher Education Act of 1965, as amended (the HEA) (20 U.S.C. 1071 et seq., 20 U.S.C. 1087a et seq., 20 U.S.C. 1087aa et seq., and 20 U.S.C. 1070g et seq.) and the authorities for collecting and using your Social Security Number (SSN) are §§428B(f) and 484(a)(4) of the HEA (20 U.S.C. 1078-2(f) and 1091(a)(4)) and §31001(i)(1) of the Debt Collection Improvement Act of 1996 (31 U.S.C. 7701(c)). Participating in the William D. Ford Federal Direct Loan (Direct Loan) Program and giving us your SSN are voluntary, but you must provide the requested information, including your SSN, to participate.

The principal purposes for collecting the information on this form, including your SSN, are to verify your identity, to determine your eligibility to receive a Direct Loan, to receive a benefit on a loan (such as a deferment, forbearance, discharge, or forgiveness), to permit the servicing of your loan(s), and, if it becomes necessary, to locate you and to collect and report on your loan(s) if your loan(s) become delinquent or in default. We also use your SSN as an account identifier and to permit you to access your account information electronically.

The information in your file may be disclosed, on a case-by-case basis or under a computer matching program, to third parties as authorized under routine uses in the appropriate systems of records notices.

For a loan, the routine uses of the information that we collect about you include, but are not limited to, its disclosure to federal, state, or local agencies, to institutions of higher education, and to third party servicers to determine your eligibility to receive a loan, to investigate possible fraud, and to verify compliance with federal student financial aid program regulations.

In the event of litigation, we may send records to the Department of Justice, a court, adjudicative body, counsel, party, or witness if the disclosure is relevant and necessary to the litigation. If this information, either alone or with other information, indicates a potential violation of law, we may send it to the appropriate authority for action. We may send information to members of Congress if you ask them to help you with federal student aid questions. In circumstances involving employment complaints, grievances, or disciplinary actions, we may disclose relevant records to adjudicate or investigate the issues. If provided for by a collective bargaining agreement, we may disclose records to a labor organization recognized under 5 U.S.C. Chapter 71. Disclosures may be made to our contractors for the purpose of performing any programmatic function that requires disclosure of records. Before making any such disclosure, we will require the contractor to maintain Privacy Act safeguards. Disclosures may also be made to qualified researchers under Privacy Act safeguards.

For a loan, the routine uses of this information also include, but are not limited to, its disclosure to federal, state, or local agencies, to private parties such as relatives, present and former employers, business and personal associates, to creditors, to financial and educational institutions, and to guaranty agencies to verify your identity, to determine your program eligibility and benefits, to permit making, servicing, assigning, collecting, adjusting, or discharging your loan(s), to enforce the terms of the loan(s), to investigate possible fraud and to verify compliance with federal student financial aid program regulations, to locate you if you become delinquent in your loan payments or if you default, or to verify whether your debt qualifies for discharge or cancellation. To provide default rate calculations, disclosures may be made to guaranty agencies, to financial and educational institutions, or to federal, state or local agencies. To provide financial aid history information, disclosures may be made to educational institutions. To assist program administrators with tracking refunds and cancellations, disclosures may be made to guaranty agencies, to financial and educational institutions, or to federal or state agencies. To provide a standardized method for educational institutions to efficiently submit student enrollment status, disclosures may be made to guaranty agencies or to financial and educational institutions. To counsel you in repayment efforts, disclosures may be made to guaranty agencies, to financial and educational institutions, or to federal, state, or local agencies.

Paperwork Reduction Notice. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a currently valid OMB control number. Public reporting burden for this collection of information is estimated to average 0.5 hours (30 minutes) per response, including time for reviewing instructions, searching existing data resources, gathering and maintaining the data needed, and completing and reviewing the collection of information. The obligation to respond to this collection is required to obtain a benefit in accordance with 34 CFR 685.219. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S Department of Education, 400 Maryland Ave., SW, Washington, DC 20210-4537 or e-mail ICDocketMgr@ed.gov and reference OMB Control Number 1845-0110. **Note: Please do not return the completed Employment Certification for Public Service Loan Forgiveness to this address.**

If you have comments or concerns regarding the status of your individual submission of this form, contact the PSLF servicer (see Section 6).