SUNY SCHENECTADY
COUNTY COMMUNITY COLLEGE

Ineligibility for Benefits

I understand, at this time, due to my position, I am ineligible for the following benefits:

- Medical Insurance
- Dental Insurance
- Vision Insurance

I understand, if my eligibility should change, I will be notified by Human Resources and that I will have 30 days from the date of the change to make an election in the benefit I am eligible for.

Name _____

Department: _____ Title: _____

First day of employment: _____

- ☐ Adjunct
- ☐ Part-time
  - Hours scheduled to work/week: _____

Employee Signature _____ Date _____