



**CLASSIFIED ADMINISTRATOR**  
 Health and Welfare Selection Form  
 Effective 1/1/2018 – 12/31/2018

If you are **NOT** making any H&W changes please check the box and sign the back of the form.

Department:

FTE: % **12 PAY**

EMPLOYEE:

DOH:

EMPLOYEE ID:

The District's Health and Welfare plan is prorated according to percentage of contract and date of hire/termination. Please mark your selections for plan year January 1, 2018 – December 31, 2018. These selections are for the entire plan year and can only be changed if there is a qualifying event (marriage, birth or loss of other coverage.) The figures below reflect the monthly payroll deductions that will be deducted from your monthly salary warrant on a pre-tax basis.

	Selecting a District Medical Plan	Waiving/Opting Out of a Medical Plan
<b>MANDATORY COVERAGES:</b> Employee must select and maintain option A and B for an entire year.	12 Month Payroll Pre-Tax Deductions	Monthly Rates
<b>A. DENTAL</b>		
<input type="checkbox"/> Delta Dental – Employee Only	\$0	\$53.04
<input type="checkbox"/> Delta Dental – Employee + 1 dependent	\$0	\$107.93
<input type="checkbox"/> Delta Dental – Employee + 2 or more dependents	\$0	\$152.16
<input type="checkbox"/> MetLife Dental HMO – Employee + dependents	\$0	\$29.92
<b>B. LIFE INSURANCE</b>		
<input checked="" type="checkbox"/> Hartford (Employee Only--\$50,000)	\$0	\$10.50
<b>OPTIONAL SELECTIONS</b>	Selecting a District Medical Plan	Waiving/Opting Out of a Medical Plan
<b>C. MEDICAL</b>		
<input type="checkbox"/> Waive Medical		
<input type="checkbox"/> Kaiser – Employee Only	\$0	
<input type="checkbox"/> Kaiser – Employee + 1 dependent	\$229.60	
<input type="checkbox"/> Kaiser – Employee + 2 or more dependents	\$323.80	
<input type="checkbox"/> UHC Network #1 – Employee Only	\$50.00	
<input type="checkbox"/> UHC Network #1 – Employee + 1 dependent	\$457.60	
<input type="checkbox"/> UHC Network #1 – Employee + 2 or more dependents	\$634.80	
<input type="checkbox"/> UHC Network #2 – Employee Only	\$264.00	
<input type="checkbox"/> UHC Network #2 – Employee + 1 dependent	\$883.60	
<input type="checkbox"/> UHC Network #2 – Employee + 2 or more dependents	\$1,235.80	
<input type="checkbox"/> UHC Network #3 – Employee Only	\$430.00	
<input type="checkbox"/> UHC Network #3 – Employee + 1 dependent	\$1,205.60	
<input type="checkbox"/> UHC Network #3 – Employee + 2 or more dependents	\$1,690.80	
<input type="checkbox"/> UHC Alliance HMO – Employee Only	\$192.00	
<input type="checkbox"/> UHC Alliance HMO – Employee + 1 dependent	\$683.60	
<input type="checkbox"/> UHC Alliance HMO – Employee + 2 or more dependents	\$930.80	
<input type="checkbox"/> UHC PPO – Employee Only	\$812.00	
<input type="checkbox"/> UHC PPO – Employee +1 dependent	\$1,954.60	
<input type="checkbox"/> UHC PPO – Employee + 2 or more dependents	\$2,731.80	
<b>D. VISION</b>		
<input type="checkbox"/> Waive Vision		
<input type="checkbox"/> MES – Employee Only	\$8.19	\$8.19
<input type="checkbox"/> MES – Employee + 1 dependent	\$16.32	\$16.32
<input type="checkbox"/> MES – Employee + 2 or more dependents	\$24.57	\$24.57

CLASSIFIED ADMINISTRATOR

Authorized Pre-Tax Deduction	Authorized After Tax Deduction
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**E. CANCER CARE PLANS**

<input type="checkbox"/> AFLAC	Various	
<input type="checkbox"/> American Fidelity	Various	
<input type="checkbox"/> Pacific Educators	Various	

**F. ACCIDENT/HOSPITAL/ILLNESS/SICK**

<input type="checkbox"/> AFLAC – Hospital Intensive Care	Various	
<input type="checkbox"/> AFLAC – Personal Accident	Various	
<input type="checkbox"/> AFLAC – Personal Sickness/Hospital	Various	
<input type="checkbox"/> American Fidelity – Accident/Crit. Illness	Various	

**G. DISABILITY INCOME INSURANCE**

<input type="checkbox"/> AFLAC	Various	
<input type="checkbox"/> American Fidelity	Various	
<input type="checkbox"/> CSCP – Pacific Educators	Various	
<input type="checkbox"/> JC Insurance ( <b>Existing members only</b> )	Various	
<input type="checkbox"/> The Standard	Various	

**H. ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE**

<input type="checkbox"/> JC Insurance ( <b>Existing members only</b> )	Various	
<input type="checkbox"/> The Hartford (SDCOE FBC)	Various	
<input type="checkbox"/> Prudential (previously MetLife)	Various	

**I. LIFE INSURANCE**

<input type="checkbox"/> American Fidelity	Various	
<input type="checkbox"/> JC Insurance ( <b>Existing members only</b> )	Various	
<input type="checkbox"/> Hartford Supplemental	Various	
<input type="checkbox"/> Prudential (previously MetLife)	Various	
<input type="checkbox"/> Pacific Educators	Various	
<input type="checkbox"/> The Standard	Various	

**J. LONG TERM CARE**

<input type="checkbox"/> UNUM	Various	
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**K. TAX SHELTERED ANNUITIES – TAX DEFERRED**

Empower FBC 457: \$ \_\_\_\_\_ Empower FBC ROTH 403(b) \$ \_\_\_\_\_ 403b: \$ \_\_\_\_\_  
 \_\_\_\_\_  
 Company Name

Selection of any new plan does not constitute automatic enrollment. Enrollment forms may be obtained from the Benefits Office or the Human Resources website. Coverage of newly selected voluntary plans will not become effective until approved by the insurance company.

I fully understand that I cannot change the status of the District’s plans in **Items A through J**, until the next open enrollment period. Furthermore, I understand that medical coverage is optional and should I decline coverage for myself and/or my dependents, I will hold the District harmless for expenses or injury incurred by me and/or my dependents.

**I hereby authorize payroll deduction(s) from my monthly salary warrant to cover the cost of selections as indicated. This authorization replaces any previous authorizations I have made.**

Signature \_\_\_\_\_

Date \_\_\_\_\_