SOUTHWESTERN COLLEGE

CLASSIFIED
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: **%** **10 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.

MANDATORY COVERAGES: Employee must select and maintain option A and B for an entire year.	**Selecting a District Medical Plan** 10 Month Payroll Pre-Tax Deductions	**Waiving/Opting Out of a Medical Plan** Monthly Rates
A. DENTAL		
☐ Delta Dental – Employee Only	$0	$63.65
☐ Delta Dental – Employee + 1 dependent	$0	$129.52
☐ Delta Dental – Employee + 2 or more dependents	$0	$182.59
☐ MetLife Dental HMO – Employee + dependents	$0	$29.92
B. LIFE INSURANCE		
☑ Hartford (Employee Only--$25,000)	$0	$6.30
OPTIONAL SELECTIONS	**Selecting a District Medical Plan**	**Waiving/Opting Out of a Medical Plan**
C. MEDICAL		
☐ Waive Medical		
☐ Kaiser – Employee Only	$0	
☐ Kaiser – Employee + 1 dependent	$275.80	
☐ Kaiser – Employee + 2 or more dependents	$388.60	
☐ UHC Network #1 – Employee Only	$60.00	
☐ UHC Network #1 – Employee + 1 dependent	$547.80	
☐ UHC Network #1– Employee + 2 or more dependents	$762.60	
☐ UHC Network #2 – Employee Only	$317.00	
☐ UHC Network #2 – Employee + 1 dependent	$1,058.80	
☐ UHC Network #2 – Employee + 2 or more dependents	$1,482.60	
☐ UHC Network #3 – Employee Only	$516.00	
☐ UHC Network #3 – Employee + 1 dependent	$1,445.80	
☐ UHC Network #3 – Employee + 2 or more dependents	$2,028.60	
☐ UHC Alliance HMO – Employee Only	$231.00	
☐ UHC Alliance HMO – Employee + 1 dependent	$818.80	
☐ UHC Alliance HMO – Employee + 2 or more dependents	$1,116.60	
☐ UHC PPO – Employee Only	$975.00	
☐ UHC PPO – Employee +1 dependent	$2,344.80	
☐ UHC PPO – Employee + 2 or more dependents	$3,278.60	
D. VISION		
☐ Waive Vision		
☐ MES – Employee Only	$9.83	$9.83
☐ MES – Employee + 1 dependent	$19.58	$19.58
☐ MES – Employee + 2 or more dependents	$29.48	$29.48

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		Authorized Pre-Tax Deduction	Authorized After Tax Deduction
E. CANCER CARE PLANS			
☐ AFLAC	Various		
☐ American Fidelity	Various		
☐ Pacific Educators	Various		
F. ACCIDENT/HOSPITAL/ILLNESS/SICK			
☐ AFLAC – Hospital Intensive Care	Various		
☐ AFLAC – Personal Accident	Various		
☐ AFLAC – Personal Sickness/Hospital	Various		
☐ American Fidelity – Accident/Crit. Illness	Various		
G. DISABILITY INCOME INSURANCE			
☐ AFLAC	Various		
☐ American Fidelity	Various		
☐ CSCP – Pacific Educators	Various		
☐ JC Insurance (**Existing members only**)	Various		
☐ The Standard	Various		
H. ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE			
☐ JC Insurance (**Existing members only)**	Various		
☐ The Hartford (SDCOE FBC)	Various		
☐ MetLife (previously Prudential)	Various		
I. LIFE INSURANCE			
☐ American Fidelity	Various		
☐ JC Insurance (**Existing members only)**	Various		
☐ Hartford Supplemental	Various		
☐ MetLife (previously Prudential)	Various		
☐ Pacific Educators	Various		
☐ The Standard	Various		
J. LONG TERM CARE			
☐ UNUM	Various		

K. TAX SHELTERED ANNUITIES – TAX DEFFERRED

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_____