SVUSD 2019 PAYROLL DEDUCTION FORM

Benefits Form MUST be attached if enrolling or making changes to your coverage

First Name:______________________ Last Name:____________________________ PIN:______________

☐Certificated ☐Classified FT ☐Classified PT-6 Hr ☐Classified PT-5 Hr ☐Classified PT-4 Hr

Effective Date:_________________________

Select your medical plan under the appropriate bargaining unit:

CSEA FT/SVMTA**	Employee Only	Employee + 1 Dependent	Employee + Family (2 or more dependents)
Blue Shield HMO Trio	☐ $50	☐ $75	☐ $100
Blue Shield Access+ HMO	☐ $50	☐ $75	☐ $100
Blue Shield PPO	☐ $100 +$258*	☐ $225 + $258*	☐ $335 +$258*
Delta Dental & VSP Vision ONLY (waive med)	☐ $0	☐ $0	☐ $0

CSEA PT*** 6 Hours per day	Employee Only	Employee + 1 Dependent	Employee + Family (2 or more dependents)
Blue Shield HMO Trio	☐ $64	☐ $1,002	☐ $1,510
Blue Shield Access+ HMO	☐ $64	☐ $1,240	☐ $1,877

CSEA PT*** 5 Hours per day	Employee Only	Employee + 1 Dependent	Employee + Family (2 or more dependents)
Blue Shield HMO Trio	☐ $213	☐ $1,150	☐ $1,658
Blue Shield Access+ HMO	☐ $262	☐ $1,438	☐ $2,075

CSEA PT*** 4 Hours per day	Employee Only	Employee + 1 Dependent	Employee + Family (2 or more dependents)
Blue Shield HMO Trio	☐ $425	☐ $1,363	☐ $1,871
Blue Shield Access+ HMO	☐ $524	☐ $1,700	☐ $2,337

SVEA**	Employee Only	Employee + 1 Dependent	Employee + Family (2 or more dependents)
Blue Shield HMO Trio	☐ $50	☐ $75	☐ $100
Blue Shield Access+ HMO	☐ $50	☐ $75	☐ $100
Blue Shield PPO	☐ $100	☐ $225	☐ $335
Delta Dental & VSP Vision ONLY (waive med)	☐ $0	☐ $0	☐ $0

SVPSA**	Employee Only	Employee + 1 Dependent	Employee + Family (2 or more dependents)
Blue Shield HMO Trio	☐ $50	☐ $75	☐ $100
Blue Shield Access+ HMO	☐ $50	☐ $75	☐ $100
Blue Shield PPO	☐ $120	☐ $225	☐ $335
Delta Dental & VSP Vision ONLY (waive med)	☐ $0	☐ $0	☐ $0

☐ **I wish to DECLINE all eligible coverage(s)**

Please read and sign:

Employees who elect medical and mental health insurance will be required to pay a portion of the cost according to the rates shown on this form. All deductions are made on a 10-month payroll cycle. Dental and vision insurance are 100% paid by the District.

- ☐ **I am covering a registered domestic partner**. Deductions for a registered domestic partner must be taken on an after-tax basis. Refer to Tax Information for Registered Domestic Partners (FTB Pub 737).
- ☐ **I am covering a same sex spouse.** Deductions for same sex marriages may be taken on a pre-tax basis.

It is the policy of the District to accept payroll contributions for medical insurance benefits on a PRE-TAX basis. This policy reduces your taxable compensation by the amount of your payroll contribution. If you do not wish to have your payroll contributions paid on a pre-tax basis, you must indicate below:

- ☐ **I elect to have my medical premiums taken on an AFTER-TAX basis.**

I understand that I cannot change my health plan election, add a dependent or change my flexible spending account election until the next annual open enrollment period, unless I have a mid-year qualifying event or change in family status. I understand that the election on my enrollment/change form will supersede any erroneous election made on this form. I confirm that enrolled dependents are eligible based on being a registered Domestic Partner, or legally married spouse from whom I am not legally separated and who is not a member on active duty with the Armed forces; or child (including stepchild, child of an eligible domestic partner, legally adopted child or foster child) who is less than 26 years of age, who is not covered for benefits as a District employee, and is not a member on active duty with the Armed Forces; and who has been enrolled and accepted by the District as a dependent and has maintained membership under terms of the plan. I understand that I must advise the Benefits Administrator of any dependents that become ineligible as a result of divorce and/or legal separation, and that failure to report ineligible dependents will result in loss of their COBRA continuation rights. In addition, I may be responsible for premiums and claim expenses paid on behalf of ineligible dependents. I **understand that I must advise the Benefits Administrator of any new dependents as the result of birth, adoption, or marriage within 31 days of the event.** Failure to notify will result in loss of coverage for that dependent until the next open enrollment period. I confirm I have filed a Declaration of Domestic Partnership in order to enroll a domestic partner, if applicable. **I understand the premium and/or PPO differential may change from year to year and I agree to pay the increased premium and/or PPO differential amount each month as long as I am enrolled in health benefits**. **I understand it is my responsibility to affect an Open Enrollment change should I not wish to pay the increased premium and/or updated PPO differential for the following year.** I authorize SVUSD to withhold premiums from my paycheck based on my election here and if there is not enough funds available, I will be responsible for submitting payment directly. I understand I must submit appropriate Benefits forms and eligibility documents, if applicable. I understand my enrollment or change will not be finalized until all required forms and/or documents are completed, signed, and approved by the Benefits Department.

Signature____Date_________________________________

*This amount represents the difference between HMO and PPO composite costs for the prior year. This differential amount will be recalculated each year.

** Medical coverage selection includes mental health, District paid Delta dental and VSP vision.

*** Coverage includes only medical and mental health.

Rev. 10/4/18