FUHSD CLASSIFIED EMPLOYEE BENEFITS

INSURANCE ENROLLMENT & WAIVER FORM

HR USE ONLY

PART 1 – EMPLOYEE INFORMATION - *FTE and Hire date will be completed by Human Resources*

Last Name	First Name	FTE	Hire Date

PART 2 - MEDICAL COVERAGE - *Choose one Medical Benefit Option Listed Below or Choose to Opt Out*

Please select one of the two choices below:

☐ **I want to Opt Out of medical coverage and receive $125 per month (per 1.0 FTE)**

☐ **I want to Enroll in the CalPERS Medical plan selected below (additional forms required):**

If you selected to Enroll in CalPERS Medical, please choose one plan below:

☐ **Kaiser** (HMO)

☐ **Blue Shield Access+** (HMO)

☐ **Blue Shield NetValue** - Same plan as Access + with fewer physicians in network (HMO)

☐ **PERS Care** - **Blue Cross** - 90/10 Plan (PPO)

☐ **PERS Choice** - **Blue Cross** - 80/20 Plan (PPO)

☐ **PERS Select** - Same as PERS Choice with fewer physicians in network (PPO)

PART 3 – DENTAL COVERAGE - *Choose one of the options listed below*

☐ **I want to Opt Out of Dental Insurance and receive $25 per mo. towards cap or in cash (per 1.0 FTE)**

☐ **I want to Enroll in the Delta Dental Insurance plan *(additional forms required)***

PART 4 – VISION CARE - *Choose one of the options listed below*

☐ **I want to Opt Out of VSP Vision Care**

☐ **I want to Enroll in the VSP Vision Care Insurance plan *(additional forms required)***

PART 5 – LIFE INSURANCE - *Choose one of the options listed below*

☐ **I would like to Opt Out of the Life Insurance plan**

☐ **I would like to Enroll in the Standard Insurance Life Insurance plan *(additional forms required)***

I understand that if I decline participation at this time and apply for this insurance at a later date, I will have to furnish, at my own expense, evidence of insurability, which is satisfactory to the Insurance Company before I can become insured.

PART 6 – FREE BENEFITS - *(additional forms required)*

X **Employee Assistance Program -** PacifiCare Behavioral Health

X **Disability Insurance -** Standard Insurance – (must work at least 15 hours per week to be eligible at no cost)

PART 7 – SIGNATURES – *Signature of Spouse or Registered Domestic Partner is required if applicable*

I wish to enroll in the selections made above. I understand that the District contribution towards benefits is fixed at $755 per month (prorated by FTE) and I will be charged for all benefit costs that exceed this amount. ***If "Opting Out" of medical coverage, I declare, under penalty of perjury, that I have medical insurance from a different source.***

Employee Signature: ______________________________ **Date:** ____________________

I hereby acknowledge that I have read all of the above and that I agree with the selections as made by my spouse.

Spouse/Partner Signature: ___________________________ **Date:** ____________________