FREMONT UNION HIGH SCHOOL DISTRICT

Cupertino High School | Fremont High School | Homestead High School | Lynbrook High School | Monta Vista High School | Adult & Community Ed.

Contribution Schedule and Premium Reduction Election Form

As a member of Fremont Education Association's bargaining unit you are eligible to participate in our employee benefits program effective on your first contractual work day. Fremont Union High School District (FUHSD) pays the entire monthly cost for your benefits and the majority of the cost for your dependents. If you elect to cover your dependents on the medical insurance plan, a contribution is required. Following is an overview of the coverages provided for you and your eligible dependents.

Benefits Provided	Benefits Funded by FUHSD		
	Employee	**Spouse/RDP**	**Child(ren)**
Medical	Yes	Partial Contribution Required	Partial Contribution Required
Dental	Yes	Yes	Yes
Vision	Yes	Yes	Yes
EAP	Yes	Yes	Yes
Life	Yes	N/A	N/A
Disability	Yes	N/A	N/A

Medical insurance contributions for full-time employees and their dependents enrolled in the plan will be taken on a salary reduction basis *each month for 10 months (according to the school's calendar year).* The contribution is the same, regardless of whether you elect to be covered under the Kaiser HMO plan or the Anthem Blue Cross PPO plan. Required contributions are as follows:

Employee only	$0*
Cost for Spouse/RDP who **does not** have access to other group coverage	$150*
Cost for Spouse/RDP who **does** have access to other group coverage	$280*
Cost for Child(ren)	$25*

A pro-rated premium is required for less than full-time employees. This premium is based on the composite cost of benefits for all Fremont Education Association (FEA) members. The spousal/RDP contribution applies **in addition to the pro-rated premium.*

* INTENT TO PARTICIPATE *

Please Print Employee Name: _____

Please indicate your decision to participate in the group benefit plans sponsored by FUHSD by checking one of the boxes in EACH of the three sections below:

STEP ONE: PLEASE SELECT ONE OPTION BELOW	
☐	Anthem Blue Cross PPO Plan
☐	Kaiser HMO Plan
☐	Not Applicable (only part-time employees electing to waive medical coverage may select this option)

STEP TWO: PLEASE SELECT ONE OPTION BELOW	
☐	Provide medical coverage for myself only.
☐	Provide medical coverage for me and my spouse/registered domestic partner.
☐	Provide medical coverage for me and my child(ren).
☐	Provide medical coverage for me, my spouse/registered domestic partner & child(ren).
☐	Waiving medical coverage
☐	I am a part-time employee (working less than full-time). I elect to waive medical, dental, vision and life insurance benefits in lieu of paying the pro-rated benefits cost. (Please sign attached waiver)

STEP THREE: PLEASE SELECT ONE OPTION BELOW	
☐	I do not have a spouse/registered domestic partner.
☐	I have a spouse/registered domestic partner and have elected to cover them above.
☐	I have a spouse/registered domestic partner, but do not want to enroll them for medical coverage. (Please sign attached waiver)

(EMPLOYEE SIGNATURE REQUIRED ON BACK OF FORM)

Employer Use Only: *Salary Reduction Amount:* _____ *Effective Date:* _____ *Processed By:* _____

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OTHER TERMS AND CONDITIONS

Statement of Understanding

I understand that I cannot change or revoke any of my elections or this salary reduction agreement at any time during the plan year unless I have a Status Change as defined in the Summary Plan Description. A status change includes marriage, divorce, death of a spouse/RDP's or child, birth or adoption of a child, termination or commencement of employment of a spouse/RDP, change in my or my spouse's/RDP's employment status from full-time to part-time, or from part-time to full-time, my spouse/RDP or I taking an unpaid leave of absence, a substantial change in my family's health coverage due to a change in my spouse's/RDP's employer-sponsored health coverage.

I understand that should I decide not to enroll my spouse/RDP for any benefits for which I am eligible at this time, I will be required to wait until the annual open enrollment unless a Special Open Enrollment event occurs in order to add any medical coverage.

In lieu of specified compensation, I hereby authorize salary reductions in the amount of current premiums being charged. I understand that if my required contributions to pay premiums for the elected benefits are increased or decreased while this agreement remains in effect, my salary reduction will automatically be adjusted to reflect that increase or decrease. The Plan Administrator may change or cancel my salary reduction or otherwise modify this agreement in the event it is advisable in order to satisfy certain nondiscrimination provisions of the IRS Code.

The salary reduction elected under this authorization shall be in addition to any reductions under other agreements or benefit programs maintained by my Employer. Any amounts that are not used during the Plan Year to provide benefits will be forfeited and may not be paid to me in cash or used to provide benefits specifically for me in the later plan year.

Prior to the first day of each Plan Year, I will be offered the opportunity to change my coverage elections for the following plan year. If I do not complete and return a new election form at that time, I will be treated as having elected to continue my coverage elections then in effect for the new Plan Year (except for FSA elections), although the required contributions for those coverage elections may change.

As an eligible employee in the above plan, I acknowledge that I have received the Summary Plan Description. I have read the Summary Plan Description and understand the benefits available to me as well as other rights and obligations which I have under the Plan. I also understand the full Plan Document is available for my review. In accordance with my rights under the Plan, I have elected certain benefits and designate the corresponding amounts for each benefit I have elected for the plan year as salary reductions. My employer and I agree that my cash compensation will be reduced by the amounts set forth above for the Plan Year (or during such portion of the year as remains after the date of this authorization).

I understand that certain social insurance benefits and compensation based employee benefit plans may provide reduced benefits based on my election to make this pre-tax salary reduction. If I elect NOT to take advantage of this pre-tax opportunity, I understand it is my responsibility to contact the Business Department for additional information about non-pre-tax alternatives.

This authorization is subject to the terms of the IRC Section 125 Pre-Tax Premium Plan adopted by my employer. It shall be governed by and construed in accordance with applicable laws and revokes any prior election and salary reduction authorization related to such plan.

SIGNATURE AND AUTHORIZATION

I have received and read all the materials explaining The Fremont Union High School District Employee Benefit Plan. I understand that I am making a binding election concerning my benefits for a full Plan Year. Furthermore, I understand that *additional enrollment documentation is required* and that no benefits will take effect until all required documentation is fully completed and submitted to the Business Department.

Date: _____ Employee Signature: _____

SS#: _____ Print Name: _____

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Waiver of Insurance Coverage

EMPLOYEE INFORMATION

Employee Name: _____ Employee Social Security Number: _____-_____-_____

Reason for Waiving Coverage

☐ Covered by spouse's/registered domestic partner's plan
(Please include carrier name AND policy number in space provided below)

☐ Other _____
(Please include carrier name AND policy number in space provided below)

Carrier Name and Policy Number of other insurance coverage:

_____

Person(s) Coverage is Being Waived For:

Last Name, First Name, MI	Birthdate (MM/DD/YY)	Social Security #
Self		-- --
Spouse/Registered DP		-- --
☐ Son ☐ Daughter		-- --
☐ Son ☐ Daughter		-- --

By signing below, ***I/we understand that should I/we decide to enroll in Fremont Unified High School District's health plan at a later date, I/we will be considered a late enrollee and will not be allowed to enroll in the health plan until the next Open Enrollment period.*** This health plan limitation will **not** apply if my I/we meet the following criteria:

1. The individual must meet the following criteria:
   a. was covered under another group health plan at the time this coverage was waived, and
   b. certified at the time of initial enrollment opportunity that coverage under another employer health plan was the reason for waiving coverage, providing they signed a waiver that clearly explained the penalties for late enrollment, and
   c. lost coverage as a result of termination of employment, change in employment status, termination of other plan's coverage, cessation of employer's contribution, death of a spouse/RDP, or divorce, and
   d. requests enrollment within 31 days of loss of coverage.
2. Court orders coverage of spouse/RDP or child and the request for enrollment occurs within 31 days of the court order.
3. The individual elects a different health plan during an open enrollment period with an employer offering multiple health plans.

SIGNATURE AND AUTHORIZATION

I hereby waive coverage, as indicated above, under Fremont Unified High School District's health plan. I am aware that if I waive coverage now and desire coverage more than 31 days after eligibility, I will be considered a late enrollee and will not be allowed to enroll in the health plan until the next Open Enrollment period, unless any of the above exceptions apply.

_____ _____
Employee Signature Date

_____ _____
Spouse/Registered Domestic Partner Signature Date