

Covina-Valley Unified School District Payroll Authorization

| Employee Name (First, MI, Last) | DOB | Employee SS# | Contact # | Gender |
|---------------------------------|---|--------------|--------------|--|
| | | | | <input type="checkbox"/> M <input type="checkbox"/> F |
| Address | Job Title | | School/Dept. | |
| | <input type="checkbox"/> 20-30hr. Classified employee | | | |

| For Office Use Only (Do not write in this section) | | |
|--|--|--|
| <input type="checkbox"/> New employee Hire Date: _____ <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Add Newborn DOB: _____ <input type="checkbox"/> Name Change Former name: _____ <input type="checkbox"/> Job Share (See back of form) <input type="checkbox"/> Delete Dependent (See back of form) <input type="checkbox"/> Other QE _____ Date: _____ | Hire Date: _____ Benefit Begin Date: _____ Hard Cap EXEMPT: <input type="checkbox"/> Yes <input type="checkbox"/> No Job Class: _____ EID: _____ Entered by: _____ Date Entered: _____ | Dependent/QE Documentation: <input type="checkbox"/> Tax Form <input type="checkbox"/> Marriage Affidavit <input type="checkbox"/> Marriage Certificate <input type="checkbox"/> Birth Certificate(s) <input type="checkbox"/> Hospital Birth Record <input type="checkbox"/> Adoption Court Order <input type="checkbox"/> Divorce Decree <input type="checkbox"/> Loss/Proof of Other Coverage <input type="checkbox"/> Other: _____ |

District Benefit Plans

| Medical | Dental | Vision | Basic Life Insurance | Supplemental Life Insurance |
|---|--|--|--|--|
| <input type="checkbox"/> Blue Shield PPO <input type="checkbox"/> Blue Shield Access +HMO <input type="checkbox"/> Blue Shield Trio HMO <input type="checkbox"/> Kaiser HMO <input type="checkbox"/> Waive Medical coverage* \$100 cash added to tenthly pay warrants | <input type="checkbox"/> Delta Dental PPO <input type="checkbox"/> MetLife/Safeguard DHMO <input type="checkbox"/> Waive Dental coverage | <input type="checkbox"/> VSP <input type="checkbox"/> Waive Vision coverage | <input type="checkbox"/> \$30k Voya Basic Term Life & AD&D (District Paid) | <input type="checkbox"/> Voya Voluntary Term Life <input type="checkbox"/> Employee \$ _____ <input type="checkbox"/> Spouse \$ _____ <input type="checkbox"/> Child(ren) \$ _____ <input type="checkbox"/> Voya Voluntary Term AD&D <input type="checkbox"/> Employee \$ _____ <input type="checkbox"/> Spouse \$ _____ <input type="checkbox"/> Child(ren) \$ _____ |

* I understand that should I elect to enroll myself or family members in a District-Sponsored medical plan at a later date enrollment will be subject to all of the rules in effect, including the submission of appropriate health statements and furnish any and all dependent verification documents.

Voya Beneficiary Information (All fields required)

| Voya Beneficiary Name | Relationship | Gender | Contact # | SS# | DOB |
|-----------------------|--------------|--|-----------|-----|-----|
| | | <input type="checkbox"/> M <input type="checkbox"/> F | | | |
| Address: _____ | | | | | |

Dependent Enrollment Information (All fields required for each covered dependent)

| Dependent Name (First, MI, Last) | Relationship | Gender | DOB | SS# | MEDICAL | DENTAL | VISION | VOLUNTARY LIFE | VOLUNTARY AD&D |
|----------------------------------|--------------|--|-----|-----|---|---|---|---|---|
| | | <input type="checkbox"/> M <input type="checkbox"/> F | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | <input type="checkbox"/> M <input type="checkbox"/> F | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | <input type="checkbox"/> M <input type="checkbox"/> F | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | <input type="checkbox"/> M <input type="checkbox"/> F | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | <input type="checkbox"/> M <input type="checkbox"/> F | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | <input type="checkbox"/> M <input type="checkbox"/> F | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

I have selected medical, dental, and vision coverage as indicated above and hereby authorize the district to make appropriate payroll deductions for any coverage selected. Such deductions shall not exceed that amount agreed to by my exclusive representative as approved by the Board of Education. I understand that this authorization includes any increases, decreases, or discontinuance to coincide with these changes and will remain in effect until canceled in writing by me. I further understand that insurance canceled by me ends on the last day of the month for which premiums have been paid.

Signature of employee: _____ **Date:** _____

Job share option

- ☐ I am assigning District-paid medical benefits to my job share partner.
- ☐ I am receiving District-paid medical benefits from my job share partner.
- ☐ I am opting to split the District assigned medical benefits to with my job share partner. I agree to contribute the balance of the cost of the selected medical plan in accordance with the inverse percent of our assignment as indicated below.

School Site: _____

Job Share Partner #1 Name: _____

Percentage: _____

Job Share Partner #2 Name: _____

Percentage: _____

Cancelling Coverage for Dependents

- ☐ I am cancelling dependent(s) coverage in the following plans:

| Medical | Dental & Vision | Life Insurance |
|--|--|--|
| <input type="checkbox"/> Blue Shield PPO <input type="checkbox"/> Blue Shield Access +HMO <input type="checkbox"/> Blue Shield Trio HMO <input type="checkbox"/> Kaiser HMO | <input type="checkbox"/> Delta Dental PPO <input type="checkbox"/> MetLife/Safeguard DHMO <input type="checkbox"/> VSP | <input type="checkbox"/> Voya Voluntary Term Life & ADD <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child(ren) |

Federal Public Law 99-272, Title X (COBRA) provides that covered employees are eligible for benefit extensions if they terminate, if their dependent(s) become ineligible because of age or marriage, or if they are divorced or legally separated. These employees and their enrolled dependents have the right to pay for continued coverage in the medical, dental, and vision care plans under certain circumstances.

| Last Name | First Name | Relationship | SS# | DOB | Gender |
|-----------|------------|--------------|-----|-----|--|
| | | | | | <input type="checkbox"/> M <input type="checkbox"/> F |

Address: _____

Reason for Cancellation: _____

Date: _____

| Last Name | First Name | Relationship | SS# | DOB | Gender |
|-----------|------------|--------------|-----|-----|--|
| | | | | | <input type="checkbox"/> M <input type="checkbox"/> F |

Address: _____

Reason for Cancellation: _____

Date: _____

| Last Name | First Name | Relationship | SS# | DOB | Gender |
|-----------|------------|--------------|-----|-----|--|
| | | | | | <input type="checkbox"/> M <input type="checkbox"/> F |

Address: _____

Reason for Cancellation: _____

Date: _____

| Last Name | First Name | Relationship | SS# | DOB | Gender |
|-----------|------------|--------------|-----|-----|--|
| | | | | | <input type="checkbox"/> M <input type="checkbox"/> F |

Address: _____

Reason for Cancellation: _____

Date: _____

Employee Signature: _____ **Date:** _____