MT. DIABLO UNIFIED SCHOOL DISTRICT

Benefits Office
(925) 682-8000 x 4152
benefits@mdusd.org

Here are the instruction for completing both the Medical and Dental & Vision Self-Pay forms. You may be completing either one or both.

To continue your **Medical coverage,** complete:

SELF-PAY AGREEMENT Medical (Unpaid Leave)

- Complete all sections of the form. Be sure to sign it.
- Return the form to the Benefits office and the carrier will bill you directly.

To continue your **Dental and/or Vision coverage,** complete:

SELF-PAY AGREEMENT Dental & Vision (Unpaid Leave)

- Complete all sections of the form. Be sure to sign it.
- Return this form with your ***first*** payment to the Benefits office. Make check payable to MDUSD. A stamped copy will be mailed back to you. Please retain for your records.

MDUSD
Attn: BENEFITS Department
1936 Carlotta Drive
Concord, CA 94519-1397

- After the first check, send all future payments to the fiscal department. Checks are due by the 10th of the previous month of coverage.

MDUSD
Attn: FISCAL Department
1936 Carlotta Drive
Concord, CA 94519-1397

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2024 SELF-PAY Monthly Rates
MEDICAL

	Kaiser HMO	Blue Shield Access HMO	Health Net SmartCare HMO	Anthem Select HMO	Anthem Traditional HMO	Western Health Advantage HMO	PERS Platinum Blue Cross PPO	PERS GOLD Blue Cross PPO
EMPLOYEE ONLY	$1,021.41	$1,076.84	N/A	$1,138.86	$1,339.70	$807.23	$1,314.27	$914.82
EMPLOYEE + 1 DEPENDENT	$2,042.82	$2,153.68	N/A	$2,277.72	$2,679.40	$1,614.46	$2,628.54	$1,829.64
EMPLOYEE + 2 OR MORE DEPENDENTS	$2,655.67	$2,799.78	N/A	$2,961.04	$3,483.22	$2,098.80	$3,417.10	$2,378.53

2024 SELF-PAY MONTHLY
RATES DENTAL & VISION

	DELTA DENTAL	PREMIUM DENTAL	VSP VISION
EMPLOYEE ONLY	$44.64	$55.64	$5.06
EMPLOYEE + 1 DEPENDENT	$89.29	$111.30	$10.13
EMPLOYEE + 2 OR MORE DEPENDENTS	$139.27	$173.60	$14.44

Rev 01/2024

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SELF-PAY AGREEMENT
Continuation in a CalPERS Medical Plan
(Unpaid Leave)

Name: _____ Employee ID or SSN #:_____

Address: _____

Phone #: _____ Position: _____

I wish to continue my medical plan coverage through CalPERS while taking an unpaid leave of absence. I agree to make premium payment(s) directly to the medical carrier and further agree to:

(1) In the event of a rate increase for any of the coverages, the employee will pay the amount of the increase. The District will notify the employee of rate changes through the monthly invoice.

(2) Employees may only cover eligible listed dependents who are currently enrolled under their plan. Further, it shall be the employee's responsibility to notify the District and CalPERS of any changes in address or family status to ensure dependent eligibility and continuity of coverage.

(3) The continued participation or availability of a provider cannot be guaranteed. Current plan documents and provider listings are available directly from the carrier.

Leave of Absence Dates

_____ to _____
Approved Leave Begins MM/DD/YY Approved Leave Ends MM/DD/YY

Dependent Name	Dependent Relationship	Male/Female	Date of Birth	Date of Marriage	Social Security Number

_____ _____
Employee Signature Date

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2024 SELF-PAY AGREEMENT
DENTAL & VISION (Unpaid Leave) **Effective Date:**

Name: _____ Employee ID or SSN #:_____

Address: _____

Phone #: _____ Position: _____

I wish to continue my dental and or vision coverage through the Mt. Diablo Unified School District's (District) group health plans while taking an unpaid leave of absence. I agree to make premium payment(s) and further agree to:

(1) Coverage will only be effective if the Fiscal Services Department receives the full amount equal to two (2) months premium for all coverage by the 10th of the month following cancellation. Under no circumstances may coverage be reinstated after that date.

(2) In the event of a rate increase for any of the coverages, the employee will pay the amount of the increase. The District will notify the employee of rate changes through the monthly invoice.

(3) Employees may only cover eligible listed dependents who are currently enrolled under their plan. Further, it shall be the employee's responsibility to notify the District of any changes in address or family status to ensure dependent eligibility and continuity of coverage.

(4) The continued participation or availability of a provider cannot be guaranteed. Current plan documents and provider listings are available directly from the carrier.

Effective date to start self-pay status:_____
I elect to continue the following (dental or vision):

Initial Box	Plan	# of Persons	Monthly Amount*
	Dental		
	Premium Dental		
	Vision		

* Premiums and/or benefit coverage are subject to change on an annual basis. Enrolling eligible dependents:

Dependent Name	Dependent Relationship	Male/Female	Date of Birth

_____ _____
Employee Signature Date