MOUNT OLIVE SCHOOL DISTRICT
"Ready for what comes next"

NJEHP & GSHP -
Employees hired AFTER 7/1/2020

Medical/Dental/Vision Programs 2024/2025 Worksheet

☐ ***New Enrollment*** ☐ ***Waiver*** ☐ ***Change:***
Please check off reason at right
Attach proof of change

- ☐ *Termination of insurance*
- ☐ *Marriage (Add Spouse)*
- ☐ *Divorce (Delete Spouse)*
- ☐ *Add Dependent*
- ☐ *Delete Dependent*
- ☐ *Other_____*

SEND ORIGINAL FORM TO: *Lisa Jones, Payroll* - *lisa.jones@motsd.org*

The District and I hereby agree that I have 30-days to elect Medical/Prescription, Dental and Vision coverage and that my compensation will be reduced, on a pre-tax basis, as required by P.L. Chapter 78 and/or Chapter 44 for each pay period during the plan year (or during such portion of the year as remains after the date of this agreement).

Please check off your choices for 2024/2025. Rates shown on this worksheet are monthly.

All Fields Required…….Rates are for FULL-TIME CERTIFICATED STAFF…….Please refer to your contract for benefit eligibility

Employee Name: ☐ Male ☐ Female

Address: City: State: Zip:

SSN: Date of Birth: Date of Hire:

Home Phone # : Effective Date:

Email address: Annual Salary:

If you are enrolling dependents or WAIVING coverage for any dependents (if eligible), please complete below.

Spouse:		☐M ☐F	Spouse SSN:		Spouse DOB:	
Child:		☐M ☐F	Child SSN:		Child DOB:	
Child:		☐M ☐F	Child SSN:		Child DOB:	
Child:		☐M ☐F	Child SSN:		Child DOB:	
Child:		☐M ☐F	Child SSN:		Child DOB:	

MEDICAL PLAN WAIVER OF COVERAGE

Eligible employees have the choice to waive health coverage (medical/prescription, dental and/or vision insurance) as long as the employee certifies that he/she has other medical coverage and provides proof of coverage. **Each school year**, eligible employees may choose to "opt-out" of the district's insurance benefits. Employees choosing to "opt-out" will be required to sign this release indicating that their spouse and/or dependents are covered under another health benefit program. Employees shall be told how to re-enroll in health benefits if needed, and members are responsible for informing the Business Office, in writing, of any changes in circumstances regarding health benefits. This applies to new hires after July 1st and any employment termination that is effective prior to June 30th. For the current school year, the Board shall pay "opt-out" at the negotiated amount.

Only check ONE box here if WAIVING insurance

Level of coverage I am WAIVING…… ☐ Single ☐ EE/Sp ☐ EE/Child(ren) ☐ Family

**********Dependent section above must be complete for these boxes**********

For any benefits I am waiving, I recognize the following criteria for re-entry to the insurance program:

1. Employees and their family members have the option to waive or re-enter the health insurance programs by completing an enrollment application during the annual open enrollment period.
2. The decision to waive coverage cannot change until the next July 1st annual open enrollment period. Since most employees electing to waive coverage will be doing so because they have coverage through their spouse, a "hardship provision" for re-entry is available. This provision allows employees and family members to re-enter the program, on an immediate basis, without the necessity of health questionnaires. The provision allows for re-entry only in the following situations which result in the loss of coverage through a spouse.

- * Termination of Employment
- * Divorce (copy of decree required)
- * Legal Separation (copy of decree required)
- * Death (copy of certificate required)
- * Group Contract / Policy Terminated
- * Military Discharge (Form DD214 required)

Please Note: To be eligible for the "opt-out" waiver-election, proof of alternative coverage *(copy of current medical insurance ID card or letter on company letterhead)* MUST accompany this form.

IMPORTANT PROVISION:

ELECTION / CHANGE

I cannot change or revoke these healthcare choices at any time during the plan year unless I have a change in family status (including marriage, divorce, death of a spouse or child, birth or adoption of a child, termination or commencement of employment of a spouse, or such other events as the Plan Administrator determines will permit a change or revocation of an election). Open Enrollment will occur annually in May/June for a July 1st effective date and I will be able to make changes during that time. In addition, this worksheet is not a guarantee of coverage and all plan details are located in the Benefits Guide.

YOU CAN ONLY ELECT ONE (1) MEDICAL PLAN

Medical/RX - NJ Educators Health Plan (NJEHP)

Horizon Blue Cross Blue Shield of New Jersey

Must check one box & only choose 1 medical plan

Employee	Employee/ Spouse	Employee/ Child(ren)	Family	Waiver	N/C or N/A
☐	☐	☐	☐	☐	☐

MONTHLY CONTRIBUTIONS - NJEHP				
Annual Salary	**Employee**	**Employee & Spouse**	**Employee & Child(ren)**	**Family**
$40,000 or less	1.70%	2.80%	2.20%	3.30%
$40,001-$50,000	1.90%	3.30%	2.50%	3.90%
$50,001-$60,000	2.20%	3.90%	2.80%	4.40%
$60,001-$70,000	2.50%	4.40%	3.00%	5.00%
$70,001-$80,000	2.80%	5.00%	3.30%	5.50%
$80,001-$90,000	3.00%	5.50%	3.60%	6.00%
$90,001-$100,000	3.30%	6.00%	3.90%	6.60%
$100,001-$125,000	3.60%	6.60%	4.40%	7.20%
$125,001 & greater	3.60%	6.60%	4.40%	7.20%

_____ x _____ = _____ / _____ = _____

Annual Salary | *%* | *Total Premium* | *# of Pay Periods (20 or 24)* | *PP deduction*

Medical/RX - Garden State Health Plan (GSHP)

Horizon Blue Cross Blue Shield of New Jersey

Must check one box & only choose 1 medical plan

Employee	Employee/ Spouse	Employee/ Child(ren)	Family	Waiver	N/C or N/A
☐	☐	☐	☐	☐	☐

MONTHLY CONTRIBUTIONS - GSHP				
Annual Salary	**Employee**	**Employee & Spouse**	**Employee & Child(ren)**	**Family**
$40,000 or less	1.50%	1.50%	1.50%	1.65%
$40,001-$50,000	1.50%	1.65%	1.50%	1.95%
$50,001-$60,000	1.50%	1.95%	1.50%	2.20%
$60,001-$70,000	1.50%	2.20%	1.50%	2.50%
$70,001-$80,000	1.50%	2.50%	1.65%	2.75%
$80,001-$90,000	1.50%	2.75%	1.80%	3.00%
$90,001-$100,000	1.65%	3.00%	1.95%	3.30%
$100,001-$125,000	1.80%	3.30%	2.20%	3.60%
$125,001 & greater	1.80%	3.30%	2.20%	3.60%

_____ x _____ = _____ / _____ = _____

Annual Salary | *%* | *Total Premium* | *# of Pay Periods (20 or 24)* | *PP deduction*

YOU CAN ONLY ELECT ONE (1) DENTAL PLAN

DELTA DENTAL®

DeltaCare DHMO USA

Must check one box & only choose 1 dental plan

Employee	Employee/ Spouse	Employee/ Child(ren)	Family	Waiver	N/C or N/A
☐	☐	☐	☐	☐	☐

MONTHLY CONTRIBUTIONS - DHMO Percentage of Premium - Chapter 78

Annual Salary	Employee	Employee & Spouse	Employee & Child(ren)	Family
Premium	***$18.30***	***$35.35***	***$34.72***	***$51.75***
less than $20,000	4.5%	3.0%	3.0%	3.5%
$20,000-$24,999.99	5.5%	3.0%	3.0%	3.5%
$25,000-$29,999.99	7.5%	4.0%	4.0%	4.5%
$30,000-$34,999.99	10.0%	5.0%	5.0%	6.0%
$35,000-$39,999.99	11.0%	6.0%	6.0%	7.0%
$40,000-$44,999.99	12.0%	9.0%	9.0%	8.0%
$45,000-$49,999.99	14.0%	9.0%	9.0%	10.0%
$50,000-$54,999.99	20.0%	12.0%	12.0%	15.0%
$55,000-$59,999.99	23.0%	14.0%	14.0%	17.0%
$60,000-$64,999.99	27.0%	17.0%	17.0%	21.0%
$65,000-$69,999.99	29.0%	19.0%	19.0%	23.0%
$70,000-$74,999.99	32.0%	22.0%	22.0%	26.0%
$75,000-$79,999.99	33.0%	23.0%	23.0%	27.0%
$80,000-$84,999.99	34.0%	24.0%	24.0%	28.0%
$85,000-$89,999.99	34.0%	26.0%	26.0%	30.0%
$90,000-$94,999.99	34.0%	28.0%	28.0%	30.0%
$95,000-$99,999.99	35.0%	29.0%	29.0%	30.0%
$100,000-$109,999.99	35.0%	32.0%	32.0%	35.0%
$110,000 & greater	35.0%	35.0%	35.0%	35.0%

_____	x 12	x _____	= _____	/ _____	= _____
Premium	*# of months coverage*	*%*	*Total*	*# of Pay Periods (20 or 24)*	*PP deduction*

DELTA DENTAL®

Dental PPO + Premier

Must check one box & only choose 1 dental plan

Employee	Employee/ Spouse	Employee/ Child(ren)	Family	Waiver	N/C or N/A
☐	☐	☐	☐	☐	☐

MONTHLY CONTRIBUTIONS - DPPO Percentage of Premium - Chapter 78

Annual Salary	Employee	Employee & Spouse	Employee & Child(ren)	Family
Premium	***$45.11***	***$103.76***	***$94.31***	***$163.03***
less than $20,000	4.5%	3.0%	3.0%	3.5%
$20,000-$24,999.99	5.5%	3.0%	3.0%	3.5%
$25,000-$29,999.99	7.5%	4.0%	4.0%	4.5%
$30,000-$34,999.99	10.0%	5.0%	5.0%	6.0%
$35,000-$39,999.99	11.0%	6.0%	6.0%	7.0%
$40,000-$44,999.99	12.0%	9.0%	9.0%	8.0%
$45,000-$49,999.99	14.0%	9.0%	9.0%	10.0%
$50,000-$54,999.99	20.0%	12.0%	12.0%	15.0%
$55,000-$59,999.99	23.0%	14.0%	14.0%	17.0%
$60,000-$64,999.99	27.0%	17.0%	17.0%	21.0%
$65,000-$69,999.99	29.0%	19.0%	19.0%	23.0%
$70,000-$74,999.99	32.0%	22.0%	22.0%	26.0%
$75,000-$79,999.99	33.0%	23.0%	23.0%	27.0%
$80,000-$84,999.99	34.0%	24.0%	24.0%	28.0%
$85,000-$89,999.99	34.0%	26.0%	26.0%	30.0%
$90,000-$94,999.99	34.0%	28.0%	28.0%	30.0%
$95,000-$99,999.99	35.0%	29.0%	29.0%	30.0%
$100,000-$109,999.99	35.0%	32.0%	32.0%	35.0%
$110,000 & greater	35.0%	35.0%	35.0%	35.0%

_____	x 12	x _____	= _____	/ _____	= _____
Premium	*# of months coverage*	*%*	*Total*	*# of Pay Periods (20 or 24)*	*PP deduction*

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VISION

Must check one box	Employee	Employee/ Spouse	Employee/ Child(ren)	Family	**Waiver**	N/C or N/A
	☐	☐	☐	☐	☐	☐
	$5.25	$6.30	$6.30	$6.30		

----------*Monthly Amounts*----------

**To calculate your premium per pay period, multiply the appropriate amount by 12 and divide by your number of pay periods (20 or 24).*

REQUIRED ***- Please print, sign and date this form for any enrollments/changes/waivers.***

Employee Signature _____ Date _____

Print Employee Name _____

Please make sure to return all 4 pages of this form completed and signed.

Approval/Authorization signature -

******For Payroll Office only******

Business Administrator Signature _____

Date _____