Dinuba Unified School District
2024-25 Offer of Health Insurance Under 6-Hour

Please complete this form and Return to Rosemary Romero at the District Office.

This form must be completed and returned to the District Office. Failure to return form will constitute as a declination of offered benefits.

As a variable hour, temporary or seasonal employee of the **Dinuba Unified School District** for the 2024-25 school year, you are being given the opportunity to purchase health insurance for you and your eligible children. A summary of the available insurance plan is included in this packet. If you should choose to enroll, you will be responsible for making monthly premium payments to the district's benefits office.

To request enrollment on this plan, you must submit the following items to the district's benefits office . No late enrollments will be accepted.

- A completed and signed SISC III enrollment form
- Proof of eligibility for dependent children (birth certificates/adoption paperwork)

Monthly deductions will be taken out of your payroll check for the months of August - May.

If you fail to provide the items required for enrollment, you and your dependent children will not be allowed to enroll until the next Open Enrollment Period. Members who enroll during the Open Enrollment Period will become effective **October 1** of the same year.

Blue Cross PPO Plan:	Minimum Value PPO
Individual/Family Deductible(s):	$5,000/$10,000
Out-of-Pocket Maximum	$6,350/$12,700
Hosp, Surg, X-Ray and Lab:	70%
Doctor Visits:	70%
Other Professional:	70%
Emergency Room	$100 co-pay plus 70%
Out-of-Network Payment:	Non-Par Fee
	Subject to Medical Deductible
Prescription Drug Co-pay:	$9-35/$18-90

Employee Only		**$607.80** Monthly
Employee + Child(ren)		**Not Eligible** Monthly

Initial your selection in the box to the right.

	Yes, I elect to enroll for the option indicated above
	No, I decline coverage. I understand my next opportuity will be October of the following year.

I have read and understand the above notification. I understand that if I decline coverage or fail to provide the items required for enrollment or if I fail to make payments prior to the 1st of each month, I will not be able to enroll in coverage until the district's next Open Enrollment period.

PRINT YOUR NAME CLEARLY

SOCIAL SECURITY NO. - LAST 4 DIGITS

SIGNATURE

DATE

This form will be placed in your personnel file.

RETURN TO DISTRICT OFFICE