Tamaqua Area School District
Health Insurance Election Form
PPO and Traditional Plans
Interim Plan Year 7/1/2011-12/31/2011

Employee Name: _____
(please print)

Health, Prescription Drug, Dental and Vision Insurance Program
(please mark appropriate box)

_____ I choose to **decline** all levels of coverage offered to me under the district's Health Insurance Program for myself and all eligible dependents and I certify that my dependents and I are covered by an alternate plan. In return, I elect to receive a monetary incentive in the form of paid compensation as set forth per the terms and conditions in the current contract. That amount is $1,500 per plan year (pro-rated). I must provide the district with proof of coverage for myself and all dependents on letterhead from the employer or group that sponsors the alternate plan certifying coverage as of the first day of the plan year.

_____I choose to **participate** in all levels of coverage offered to me under the district's **Traditional Health Insurance Program** for myself and all eligible dependents. The appropriate premium share as a % of my salary is stated following each choice. Please check the appropriate type of coverage based on your status:

_____ Individual Coverage-. 75% of salary (coverage for employee only)
_____Two-Party Coverage-1.25% of salary (coverage for employee & one dependent)
_____Family Coverage- 1.75% of salary (coverage for employee and two or = more dependents)

I choose to **participate** in all levels of coverage offered to me under the district's **PPO Health Insurance Program** for myself and all eligible dependents. The appropriate premium share as a % of my salary is stated following each choice. Please check the appropriate type of coverage based on your status:

_____ Individual Coverage- . 69% of salary (coverage for employee only)
_____Two-Party Coverage-1.15% of salary (coverage for employee & one dependent)
_____Family Coverage- 1.61% of salary (coverage for employee and two or = more dependents

continued on reverse side----------

****** You are automatically eligible for coverage for yourself and all dependents as defined by the plan (spouse, children). If you choose a lower level of coverage you must provide the district with proof of alternate insurance for all members of your family for whom you are declining coverage.

****** **Married couples** employed by the district are **not** eligible for the cash incentive. One member of the couple will be responsible for premium share. The spouse whose birthday falls closest to January 1st will be primary on the plan and will be subject to premium share. All other family members will be covered as dependents of the employee paying the premium share.

****** Unless there is a qualifying event as defined by Section 125 of the Internal Revenue Service and our plan document, these elections will remain in force for the plan year as stated above. It is your responsibility to notify the district of any qualifying events and requested changes in levels of coverage.

By signing this election form, I agree to the terms as listed on this form and to all other terms as stated in the current contract and laws that govern these elections.

Signature _____

Date _____

All Eligible Employees Must Complete this Form