san diego county office of EDUCATION
FUTURE WITHOUT BOUNDARIES℠

HEALTH BENEFITS COVER SHEET

Employee Name: _____ **Social Security Number:** _____

◯ Board ◯ Certificated, non-management ◯ Confidential ◯ Classified Support ◯ Management

Benefits Effective Date: _____ ☐ **10-pay** ☐ **12-pay**

Employer-Paid Benefits (Employee only):

☒ Basic Life and AD&D Insurance (Two times annual salary, minimum $50,000/maximum $250,000)

Employer-Paid Benefits (Employee + all eligible dependents):

Dental Insurance:

☐ Delta Dental Premier
☐ United Healthcare Dental PPO Network 30

Vision Insurance:

☒ Vision Service Plan

Employer/Employee-Paid Benefits (Employee only, Employee + 1, Employee + Family) **Premium Amount**: _____

Medical Insurance:

☐ United Healthcare Performance HMO
☐ United Healthcare Alliance HMO
☐ United Healthcare Harmony HMO
☐ United Healthcare Journey HMO
☐ Surest PPO 5000 (A United Healthcare Company)
☐ Kaiser Permanente
☐ Not electing medical coverage at this time

☐ **Pre-tax**: I elect to participate in the Section 125 Premium Only Plan. I authorize the San Diego County Office of Education to reduce my salary in the amount necessary to pay for the coverage checked above.

☐ **Post-tax**: I elect **NOT** to participate in the Section 125 Premium Only Plan. By NOT electing to participate in the Section 125 Premium Only Plan, I understand that my insurance premiums will NOT be deducted pre-tax.

List below all other persons covered by these enrollments. Only your spouse and eligible dependent children may be included. Use an additional sheet if necessary. Please include the required dependent eligibility documentation separately.

Last Name, First Name, Middle Initial	Spouse/Child	Date of Birth	SSN
	N/A		
	N/A		
	N/A		
	N/A		

☐ I decline to cover dependents at this time.

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This election form revokes any prior election form completed and will remain in effect and cannot be revoked or changed during the plan year, unless the revocation and new election are on account of and consistent with a change in family status (e.g. marriage, divorce, death of a spouse or child, birth or adoption of child, and termination of employment of spouse). Participation in this plan will automatically cease upon termination of an employee's employment.

Signature of Employee: _____ **Date**: _____