



**Legacy Plans - Direct 10,
Direct 15, & Direct 20/30**

**2026/2027 Medical/Dental/Vision
Health Insurance Worksheet**

New Enrollment

Waiver

Change:

*Please check off reason at right and **MUST ATTACH PROOF OF CHANGE***

- Termination of insurance
- Marriage (Add Spouse)
- Divorce (Delete Spouse)
- Add Dependent
- Delete Dependent
- Other _____

Please check off your choice for each individual plan. Premiums shown on this worksheet are monthly.

The District and I hereby agree that I have 30-days from my date of hire or change in current position to elect Medical/Prescription, Dental and/or Vision coverage or to waive coverage and that my compensation will be reduced if I elect to enroll in coverage, 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).

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

Employee Name:		<input type="checkbox"/> Male	<input type="checkbox"/> Female
Address:	City:	State:	Zip:
SSN:	Date of Birth:	Date of Hire:	
Phone Number :	Effective Date:		
Email address:	<input type="checkbox"/> Full-Time	<input type="checkbox"/> Part-Time	
School/Location:	Position:	Number of Hours per week:	
→ DEPENDENTS: If you are ENROLLING or WAIVING coverage for any dependents (if eligible), please complete below.			
(Check one box)			
Spouse:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Spouse SSN: _____	Spouse DOB: _____
Child:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Child SSN: _____	Child DOB: _____
Child:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Child SSN: _____	Child DOB: _____
Child:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Child SSN: _____	Child DOB: _____
Child:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Child SSN: _____	Child DOB: _____
Child:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Child SSN: _____	Child DOB: _____
Child:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Child SSN: _____	Child DOB: _____

MEDICAL PLAN WAIVER OF COVERAGE (This box is for those WAIVING Medical coverage ONLY)

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 Human Resources, in writing, of any changes in circumstances regarding health benefits. This applies to new hires after July 1st and any terminations prior to June 30th. For the current school year, the Board shall pay "opt-out" at the negotiated amounts.

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 completed for these boxes****

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

- 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 (which is in May/June for a July 1st effective date every year).
- 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 (proof required with last day of benefits)
 - * 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 and reimbursement, proof of alternative coverage (copy of current medical insurance ID card or letter on company letterhead) MUST accompany this form.

IMPORTANT PROVISION:

ELECTION / CHANGE

By signing this form, I understand that I cannot change or revoke these healthcare choices at any time during the plan year unless I have a qualifying life event (such as... 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 every year 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.

*******MEDICAL/PRESCRIPTION PLAN*******

Choose only 1 plan:

Direct 10
(Administrators only)

Direct 15

Direct 20/30

Level of Coverage:

(Must check one box)

Employee

Employee/Spouse

Employee/Child(ren)

Family

WAIVER

No Change
OR
Not Applicable

Rates for calculating your cost if this plan is chosen:

Medical/Prescription - Direct 10 (Administrators Only)



2026/2027 MONTHLY CONTRIBUTIONS - DIRECT 10 Percentage of Premium - Chapter 78				
Annual Salary	Employee	Employee & Spouse	Employee & Child(ren)	Family
Premium	\$1,353.25	\$2,706.53	\$2,516.71	\$3,870.34
less than \$20,000	4.5%	3.5%	3.5%	3.0%
\$20,000-\$24,999.99	5.5%	3.5%	3.5%	3.0%
\$25,000-\$29,999.99	7.5%	4.5%	4.5%	4.0%
\$30,000-\$34,999.99	10.0%	6.0%	6.0%	5.0%
\$35,000-\$39,999.99	11.0%	7.0%	7.0%	6.0%
\$40,000-\$44,999.99	12.0%	8.0%	8.0%	7.0%
\$45,000-\$49,999.99	14.0%	10.0%	10.0%	9.0%
\$50,000-\$54,999.99	20.0%	15.0%	15.0%	12.0%
\$55,000-\$59,999.99	23.0%	17.0%	17.0%	14.0%
\$60,000-\$64,999.99	27.0%	21.0%	21.0%	17.0%
\$65,000-\$69,999.99	29.0%	23.0%	23.0%	19.0%
\$70,000-\$74,999.99	32.0%	26.0%	26.0%	22.0%
\$75,000-\$79,999.99	33.0%	27.0%	27.0%	23.0%
\$80,000-\$84,999.99	34.0%	28.0%	28.0%	24.0%
\$85,000-\$89,999.99	34.0%	30.0%	30.0%	26.0%
\$90,000-\$94,999.99	34.0%	30.0%	30.0%	28.0%
\$95,000-\$99,999.99	35.0%	30.0%	30.0%	29.0%
\$100,000-\$109,999.99	35.0%	35.0%	35.0%	32.0%
\$110,000 & greater	35.0%	35.0%	35.0%	35.0%

$$\begin{array}{ccccccccccc}
 \$ & & \times 12 & \times & \% & = & \$ & / & = & \$ \\
 \text{Premium} & & \text{Months of Coverage} & & \% & & \text{Total} & & \text{\# of Pay Periods} & & \text{Per Pay Period} \\
 & & & & & & & & (20 \text{ or } 24) & & \text{deduction}
 \end{array}$$

Rates for calculating your cost if this plan is chosen:

Medical/Prescription - Direct 15



2026/2027 MONTHLY CONTRIBUTIONS - DIRECT 15 Percentage of Premium - Chapter 78				
Annual Salary	Employee	Employee & Spouse	Employee & Child(ren)	Family
Premium	\$1,295.41	\$2,597.62	\$2,406.52	\$3,700.31
less than \$20,000	4.5%	3.5%	3.5%	3.0%
\$20,000-\$24,999.99	5.5%	3.5%	3.5%	3.0%
\$25,000-\$29,999.99	7.5%	4.5%	4.5%	4.0%
\$30,000-\$34,999.99	10.0%	6.0%	6.0%	5.0%
\$35,000-\$39,999.99	11.0%	7.0%	7.0%	6.0%
\$40,000-\$44,999.99	12.0%	8.0%	8.0%	7.0%
\$45,000-\$49,999.99	14.0%	10.0%	10.0%	9.0%
\$50,000-\$54,999.99	20.0%	15.0%	15.0%	12.0%
\$55,000-\$59,999.99	23.0%	17.0%	17.0%	14.0%
\$60,000-\$64,999.99	27.0%	21.0%	21.0%	17.0%
\$65,000-\$69,999.99	29.0%	23.0%	23.0%	19.0%
\$70,000-\$74,999.99	32.0%	26.0%	26.0%	22.0%
\$75,000-\$79,999.99	33.0%	27.0%	27.0%	23.0%
\$80,000-\$84,999.99	34.0%	28.0%	28.0%	24.0%
\$85,000-\$89,999.99	34.0%	30.0%	30.0%	26.0%
\$90,000-\$94,999.99	34.0%	30.0%	30.0%	28.0%
\$95,000-\$99,999.99	35.0%	30.0%	30.0%	29.0%
\$100,000-\$109,999.99	35.0%	35.0%	35.0%	32.0%
\$110,000 & greater	35.0%	35.0%	35.0%	35.0%

$$\begin{array}{ccccccccccc}
 \$ & & \times 12 & \times & \% & = & \$ & / & = & \$ \\
 \text{Premium} & & \text{Months of Coverage} & & \% & & \text{Total} & & \text{\# of Pay Periods} & & \text{Per Pay Period} \\
 & & & & & & & & (20 \text{ or } 24) & &
 \end{array}$$

Rates for calculating your cost if this plan is chosen:

Medical/Prescription - Direct 20/30



2026/2027 MONTHLY CONTRIBUTIONS - DIRECT 20/30 Percentage of Premium - Chapter 78				
Annual Salary	Employee	Employee & Spouse	Employee & Child(ren)	Family
Premium	\$1,167.01	\$2,334.01	\$2,170.64	\$3,337.66
less than \$20,000	4.5%	3.5%	3.5%	3.0%
\$20,000-\$24,999.99	5.5%	3.5%	3.5%	3.0%
\$25,000-\$29,999.99	7.5%	4.5%	4.5%	4.0%
\$30,000-\$34,999.99	10.0%	6.0%	6.0%	5.0%
\$35,000-\$39,999.99	11.0%	7.0%	7.0%	6.0%
\$40,000-\$44,999.99	12.0%	8.0%	8.0%	7.0%
\$45,000-\$49,999.99	14.0%	10.0%	10.0%	9.0%
\$50,000-\$54,999.99	20.0%	15.0%	15.0%	12.0%
\$55,000-\$59,999.99	23.0%	17.0%	17.0%	14.0%
\$60,000-\$64,999.99	27.0%	21.0%	21.0%	17.0%
\$65,000-\$69,999.99	29.0%	23.0%	23.0%	19.0%
\$70,000-\$74,999.99	32.0%	26.0%	26.0%	22.0%
\$75,000-\$79,999.99	33.0%	27.0%	27.0%	23.0%
\$80,000-\$84,999.99	34.0%	28.0%	28.0%	24.0%
\$85,000-\$89,999.99	34.0%	30.0%	30.0%	26.0%
\$90,000-\$94,999.99	34.0%	30.0%	30.0%	28.0%
\$95,000-\$99,999.99	35.0%	30.0%	30.0%	29.0%
\$100,000-\$109,999.99	35.0%	35.0%	35.0%	32.0%
\$110,000 & greater	35.0%	35.0%	35.0%	35.0%

$$\begin{array}{r}
 \$ \\
 \text{Premium}
 \end{array}
 \times \frac{12}{\text{Months of Coverage}}
 \times \frac{\%}{\%}
 = \frac{\$}{\text{Total}}
 \div \frac{\text{\# of Pay Periods}}{(20 \text{ or } 24)}
 = \frac{\$}{\text{Per Pay Period}}$$

*******DENTAL PLAN*******

Choose only 1 plan:

DeltaCare HMO USA

Delta PPO + Premier

Level of Coverage:

(Must check one box)

Employee

Employee/Spouse

Employee/Child(ren)

Family

WAIVER

No Change
OR
Not Applicable

Rates for calculating your cost if this plan is chosen:

DeltaCare Dental HMO USA



2026/2027 MONTHLY CONTRIBUTIONS - DHMO Percentage of Premium - Chapter 78				
Annual Salary	Employee	Employee & Spouse	Employee & Child(ren)	Family
Premium	\$17.95	\$34.68	\$34.06	\$50.77
less than \$20,000	4.5%	3.5%	3.5%	3.0%
\$20,000-\$24,999.99	5.5%	3.5%	3.5%	3.0%
\$25,000-\$29,999.99	7.5%	4.5%	4.5%	4.0%
\$30,000-\$34,999.99	10.0%	6.0%	6.0%	5.0%
\$35,000-\$39,999.99	11.0%	7.0%	7.0%	6.0%
\$40,000-\$44,999.99	12.0%	8.0%	8.0%	7.0%
\$45,000-\$49,999.99	14.0%	10.0%	10.0%	9.0%
\$50,000-\$54,999.99	20.0%	15.0%	15.0%	12.0%
\$55,000-\$59,999.99	23.0%	17.0%	17.0%	14.0%
\$60,000-\$64,999.99	27.0%	21.0%	21.0%	17.0%
\$65,000-\$69,999.99	29.0%	23.0%	23.0%	19.0%
\$70,000-\$74,999.99	32.0%	26.0%	26.0%	22.0%
\$75,000-\$79,999.99	33.0%	27.0%	27.0%	23.0%
\$80,000-\$84,999.99	34.0%	28.0%	28.0%	24.0%
\$85,000-\$89,999.99	34.0%	30.0%	30.0%	26.0%
\$90,000-\$94,999.99	34.0%	30.0%	30.0%	28.0%
\$95,000-\$99,999.99	35.0%	30.0%	30.0%	29.0%
\$100,000-\$109,999.99	35.0%	35.0%	35.0%	32.0%
\$110,000 & greater	35.0%	35.0%	35.0%	35.0%

$$\begin{array}{r}
 \text{Monthly Premium} \\
 \text{(see chart above in this section)}
 \end{array}
 \times \frac{12}{\text{\# of months coverage}}
 \times \frac{\%}{\%}
 = \frac{\text{Total}}{\text{\# of Pay Periods}}
 \div \frac{\text{\# of Pay Periods}}{(20 \text{ or } 24)}
 = \frac{\text{Per Pay Period deduction}}{\text{Per Pay Period}}$$

Rates for calculating your cost if this plan is chosen:

Dental PPO + Premier



2026/2027 MONTHLY CONTRIBUTIONS - DPPO Percentage of Premium - Chapter 78				
Annual Salary	Employee	Employee & Spouse	Employee & Child(ren)	Family
Premium	\$50.34	\$113.53	\$103.19	\$178.37
less than \$20,000	4.5%	3.5%	3.5%	3.0%
\$20,000-\$24,999.99	5.5%	3.5%	3.5%	3.0%
\$25,000-\$29,999.99	7.5%	4.5%	4.5%	4.0%
\$30,000-\$34,999.99	10.0%	6.0%	6.0%	5.0%
\$35,000-\$39,999.99	11.0%	7.0%	7.0%	6.0%
\$40,000-\$44,999.99	12.0%	8.0%	8.0%	7.0%
\$45,000-\$49,999.99	14.0%	10.0%	10.0%	9.0%
\$50,000-\$54,999.99	20.0%	15.0%	15.0%	12.0%
\$55,000-\$59,999.99	23.0%	17.0%	17.0%	14.0%
\$60,000-\$64,999.99	27.0%	21.0%	21.0%	17.0%
\$65,000-\$69,999.99	29.0%	23.0%	23.0%	19.0%
\$70,000-\$74,999.99	32.0%	26.0%	26.0%	22.0%
\$75,000-\$79,999.99	33.0%	27.0%	27.0%	23.0%
\$80,000-\$84,999.99	34.0%	28.0%	28.0%	24.0%
\$85,000-\$89,999.99	34.0%	30.0%	30.0%	26.0%
\$90,000-\$94,999.99	34.0%	30.0%	30.0%	28.0%
\$95,000-\$99,999.99	35.0%	30.0%	30.0%	29.0%
\$100,000-\$109,999.99	35.0%	35.0%	35.0%	32.0%
\$110,000 & greater	35.0%	35.0%	35.0%	35.0%

$$\frac{\text{Monthly Premium (see chart above in this section)} \times 12}{\text{\# of months coverage}} \times \text{\%} = \text{Total} \div \frac{\text{\# of Pay Periods (20 or 24)}}{\text{Per Pay Period deduction}} =$$

*******VISION PLAN*******

Rates for calculating your cost if this plan is chosen:

VISION Insights Network



Level of Coverage:
(Must check one box)

Employee	Employee/Spouse	Employee/Child(ren)	Family	Waiver	No Change OR Not Applicable
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
\$9.55	\$18.16	\$19.11	\$28.10		

-----Monthly Premiums-----

$$\frac{\text{Monthly Premium (see above in this section)} \times 12}{\text{\# of months coverage}} \times \text{Employee Contribution } 50\% = \text{Total} \div \frac{\text{\# of Pay Periods (20 or 24)}}{\text{Per Pay Period deduction}} =$$

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

Print Employee Name _____

Date _____

Employee Signature _____

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

Approval/Authorization signature -

*****For Human Resources Office only*****

Business Administrator Signature _____

Date _____