NORTH FORK
LOCAL SCHOOL DISTRICT

2026 / 2027 Benefit Election Form

Employee Name				Social Security Number
Address		City		ST Zip
Gender	Marital Status	Home Phone Number		Email Address
Date of Birth	Hours per Week	Date of Hire/Rehire	Title	

Benefit eligible employees and their eligible dependents may enroll in benefits offered by North Fork Local Schools. The monthly contributions listed below will be split between the first and second pays of each month on a pre-tax basis and will continue as long as the employee is enrolled in the plan(s).

COVERED FAMILY MEMBERS (List only dependents you wish to enroll)

Check the benefit category elected for each family member

Family Member Name	Relationship	SSN	Birthdate	Gender
				☐M ☐F
				☐M ☐F
				☐M ☐F
				☐M ☐F

MEDICAL – Medical Mutual of Ohio – Cost Per Month (12)

HDHP 3400/6800 SuperMed Plus	**CERTIFIED STAFF**	☐ Employee Only **$145.12**	☐ Family **$361.69**
	CLASSIFIED STAFF	☐ Employee Only **$145.12**	☐ Family **$482.25**

WAIVE Medical Coverage ☐
Reason for Waiving: _____

If you enroll in the Medical plan, you are eligible to contribute to a Health Savings Account (HSA). If you would like to elect or change your HSA contributions, contact Stacey Hale (Ext. 1006 or 740.892.3206).

DENTAL – MetLife – Cost Per Month (12)

☐ Employee Only **$7.06**	☐ Family **$59.29**

☐ **I am waiving Dental Coverage**

Reason for waiving:

VISION – VSP – Cost Per Month (12)			
☐ Employee Only **$9.90**	☐ Family **$31.36**	☐ Employee + Children **$18.61**	☐ Employee + 1 **$18.19**
☐ **I am waiving Vision Coverage**			
Reason for waiving:			

☐ I understand that if I and/or my dependents, if any, waive coverage and desire to participate in the plan at a later date, coverage may be subject to treatment as a late enrollee and may apply at next open enrollment period. I further understand that if I decline enrollment for myself or my dependents (including my spouse) because of other health coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 30 days after such coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependent

Employee Signature Date

Employee Print Date