



Benefit Coverage Election / Declination form

Personnel Use only:	
Certificated:	☐
Classified:	☐
Management:	☐
FTE:	
Location:	
Hire Date:	
Number of months:	

Name: _____

Social Security #: _____

I have been offered the opportunity of participating in my employer's benefits programs and I elect/decline as indicated below:
(Check the appropriate boxes below)

	ELECT (Self only)	ELECT (Self & Dependent)	DECLINE
Kaiser	☐	☐	☐
United Healthcare	☐	☐	☐
Delta Dental	☐	☐	☐
Indemnity Dental	☐	☐	☐
VSP Vision Service	☐	☐	☐
Ochs Securian Life Insurance	☐	☐	☐

☐ I / My dependents have other coverage:

Name of the Plan	Policy #

☐ Other reason (please explain):

I understand that if I decline medical coverage at this time, I/my dependents will need to provide satisfactory medical evidence of insurability in order to be covered at a later date.

I understand that if I declined dental coverage at this time, I will not be able to enroll until a specified dental open enrollment period becomes available.

Signature _____

Date _____

** Important

If this form is not completed and received by the District Office within 30 days of your hire/eligibility date, you may lose your eligibility status. This form must be returned by _____.