**PENNSBURY SCHOOL DISTRICT**
**SUPPORT STAFF OPEN ENROLLMENT FORM (*21 PAYS*) – BENEFIT PERIOD 07/01/2022 to 6/30/2023**

Employee Name: _____ Position: _____
Home Address _____ Work Location: _____
_____ Date of Birth: _____
Home Phone: _____ Social Security #: _____

**Please fill in the box next to each coverage in which you would like to enroll. The amount is the employee cost listed on a PER-PAY basis for employees paid over a 12-month period (26 pays). For employees paid over a 10-month period, the employee cost per pay will be higher since the annual employee cost is deducted from only 21 pays.**

****IS THIS A CHANGE IN INSURANCE PLANS:** ☐ **Yes, this is a change** ☐ **No, this is the same insurance as last year.**
☐ **Waiving insurance**-complete form attached ☐ **Dependents** changed

| **Medical Plans:** | **Single** | **Parent/Child** | **Parent/Children** | **Employee/Spouse** | **Family** |
|---|---|---|---|---|---|
| PPO 20/40 | ☐ $ 39.37 | ☐ $ 60.91 | ☐ $ 85.89 | ☐ $ 90.86 | ☐ $ 116.93 |
| PPO 10/20 | ☐ $ 50.81 | ☐ $ 78.22 | ☐ $110.76 | ☐ $117.18 | ☐ $ 150.49 |
| QPOS 30/40 Primary Care Physician # _____ | ☐ $ 33.85 | ☐ $ 52.56 | ☐ $ 73.89 | ☐ $ 78.17 | ☐ $ 100.74 |

| **Prescription Plan:** | **Single** | **Parent/Child** | **Parent/Children** | **Employee/Spouse** | **Family** |
|---|---|---|---|---|---|
| RX 15/30/50 | ☐ $ 9.72 | ☐ $ 14.71 | ☐ $ 21.14 | ☐ $ 22.37 | ☐ $ 28.53 |

**** IS THIS A CHANGE IN DENTAL PLANS:** ☐ **Yes, this is a change** ☐ **No, this is the same insurance as last year.**
☐ **Dependents** changed

| **Dental Plans:** | **Single** | **Parent/Child** | **Parent/Children** | **Employee/Spouse** | **Family** |
|---|---|---|---|---|---|
| UCCI Dental FLEX (PPO) | ☐ $ 2.06 | ☐ $ 5.67 | ☐ $ 5.67 | ☐ $ 5.67 | ☐ $ 5.67 |
| UCCI Dental PLUS (DHMO) | ☐ $ 1.66 | ☐ $ 4.79 | ☐ $ 4.79 | ☐ $ 4.79 | ☐ $ 4.79 |
| Delta Dental Premier Plan | ☐ $ 7.05 | ☐ $17.58 | ☐ $17.58 | ☐ $17.58 | ☐ $17.58 |

**Dependents:** **Name** **Social Security Number** **Birth Date** **Sex**

Spouse_____
Dependent_____
Dependent_____
Dependent_____
Dependent_____

**Authorization:**
I authorize the above selections and pre-tax contributions listed on this form until 6/30/2023. If I have not selected medical coverage, I certify that I have adequate medical coverage for myself and my dependents elsewhere. I agree that if I lose my medical coverage, I will notify the Human Resource office within 30 days from the loss of coverage date and will enroll in a Pennsbury plan. If for any reason, I waive medical coverage and as a result, incur any medical expenses that are uncovered, I recognize that these expenses may be my or my family's personal obligation. I agree that if I have a life event (marriage, death, birth of a child, divorce or loss of coverage), I will notify the Pennsbury Human Resource office within 30 days if I wish to change my elections. I understand that certain benefits require insurance applications and if I do not complete the required forms I will not be covered by those benefits. The plan administrator will correct any calculation error made on this form; however, elections made on this form, despite any calculation errors, will be deemed to be authorized by myself.

EMPLOYEE SIGNATURE: _____ DATE: _____

Benefit Deductions will be made on a pre-tax basis unless directed otherwise. Please indicate here if you do not want your deduction to be on a pre-tax basis for the applicable savings: _____ I do not want my benefit deductions taken on a pre-tax basis but on an after tax basis.