

**PENNSBURY SCHOOL DISTRICT
CERTIFIED/PROFESSIONAL STAFF
OPEN ENROLLMENT FORM (26 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	<input type="checkbox"/> \$ 34.07	<input type="checkbox"/> \$ 52.71	<input type="checkbox"/> \$ 74.33	<input type="checkbox"/> \$ 78.63	<input type="checkbox"/> \$ 101.19
PPO 10/20	<input type="checkbox"/> \$ 43.31	<input type="checkbox"/> \$ 66.69	<input type="checkbox"/> \$ 94.42	<input type="checkbox"/> \$ 99.88	<input type="checkbox"/> \$ 128.29
QPOS 30/40 Primary Care Physician # _____	<input type="checkbox"/> \$ 29.29	<input type="checkbox"/> \$ 45.49	<input type="checkbox"/> \$ 63.94	<input type="checkbox"/> \$ 67.64	<input type="checkbox"/> \$ 87.18
PPO 20/20	<input type="checkbox"/> \$ 45.75	<input type="checkbox"/> \$ 70.38	<input type="checkbox"/> \$ 99.73	<input type="checkbox"/> \$105.50	<input type="checkbox"/> \$ 135.46

Prescription Plan:	Single	Parent/Child	Parent/Children	Employee/Spouse	Family
RX 15/30/50	<input type="checkbox"/> \$ 8.41	<input type="checkbox"/> \$ 12.73	<input type="checkbox"/> \$ 18.30	<input type="checkbox"/> \$ 19.36	<input type="checkbox"/> \$ 24.69

**** 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)	<input type="checkbox"/> \$ 1.67	<input type="checkbox"/> \$ 4.58	<input type="checkbox"/> \$ 4.58	<input type="checkbox"/> \$ 4.58	<input type="checkbox"/> \$ 4.58
UCCI Dental PLUS (DHMO)	<input type="checkbox"/> \$ 1.34	<input type="checkbox"/> \$ 3.87	<input type="checkbox"/> \$ 3.87	<input type="checkbox"/> \$ 3.87	<input type="checkbox"/> \$ 3.87
Delta Dental Premier Plan	<input type="checkbox"/> \$ 5.69	<input type="checkbox"/> \$ 14.20	<input type="checkbox"/> \$ 14.20	<input type="checkbox"/> \$ 14.20	<input type="checkbox"/> \$ 14.20

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.