CHANDLER UNIFIED SCHOOL DISTRICT
2011/12 BENEFIT ELECTION/ENROLLMENT FORM

1

Employee Last Name	First Name	MI	Social Security Number	❑ Male ❑ Female
Street Address	City, State, ZIP		Birth Date	o Full-Time o Part-Time o Job-Share
Home Phone	Work Location		Hire Date (for new employees)	

Office Use Only
UHC Group Number: 709724 | Delta Dental Group Number: 4267 | School District/Employer: Chandler
Waive Coverage: | Coverage Effective Date: | Termination Date:
❑ Open Enrollment ❑ New Hire (Hire Date: _____) ❑ Status Change (Type: _____ Date: _____)

EMPLOYEE INFORMATION (You must complete this se

2 ELECT/CHANGE YOUR MEDICAL PLAN FOR 2011/12 (Choose A, B, C or D) If enrolling your spouse and/or dependents in coverage, complete Section 5 of this form.

(A) ❑ I am electing to **WAIVE** medical coverage for 2011/12. You also must complete Section 7 of this form.
(B) ❑ I am electing to enroll in the following plan for 2011/12. Indicate your plan below.
(C) ❑ I am electing to **CHANGE** my current coverage or coverage level **due to a qualifying** event for 2011/12. Indicate your plan below.
(D) ❑ I am a **NEW HIRE** and wish to enroll in medical coverage for 2011/12. Indicate your plan below.

❑ **UnitedHealthcare Choice Plus PPO**
(No Dental Coverage)

Select Your Coverage Level
- ❑ Employee Only
- ❑ Employee + Spouse
- ❑ Employee + Child(ren)
- ❑ Employee + Family (Spouse & Children)
- ❑ Spousal Share Family Coverage
  Designate deduction (individual's name)
  _____

NOTE: The out-of-pocket cost for employee only coverage is $2,793 per year, or $126.95 per pay period in 2011/12.

❑ **UnitedHealthcare Health Savings Account 1400 Plan (HSA-1400 Plan)**
(No Dental Coverage)

Select Your Coverage Level
- ❑ Employee Only
- ❑ Employee + Spouse
- ❑ Employee + Child(ren)
- ❑ Employee + Family (Spouse & Children)
- ❑ Spousal Share Family Coverage
  Designate deduction (individual's name)
  _____

Elect Your Plan Year Voluntary HSA Contribution (optional)

$_____ (Contribute up to $1,750 if you elect employee only coverage or $4,850 if you elect coverage, yourself plus one or more dependent, or $3,550 if you elect spousal share family coverage

Elect Your Plan Year HSA"Catch-Up" Contribution (optional for employees age 55 or over only)

$_____ (Contribute up to $1,000)

❑ **UnitedHealthcare Health Savings Account 2600 Plan (HSA-2600 Plan)**
(No Dental Coverage)

Select Your Coverage Level
- ❑ Employee Only
- ❑ Employee + Spouse
- ❑ Employee + Child(ren)
- ❑ Employee + Family (Spouse & Children)
- ❑ Spousal Share Family Coverage
  Designate deduction (individual's name)
  _____

Elect Your Plan Year Voluntary HSA Contribution (optional)

$ _____ (Contribute up to $649 if you elect employee only coverage, $3,749 if you elect coverage for yourself plus one or more dependents, or $1,348 if you elect spousal share family coverage)

Elect Your Plan Year HSA"Catch-Up" Contribution (optional for employees age 55 or over)

$ _____ (Contribute up to $1,000)

3 ELECT/CHANGE YOUR VOLUNTARY BENEFIT PLAN COVERAGE

Dental Coverage

Voluntary Dental CORE Plan (Delta Dental)
- ❑ **I wish to cancel coverage**
- ❑ **No change** to my current voluntary dental plan election
- ❑ **I wish to enroll** and elect the following coverage level (choose one)
  - ❑ Employee Only
  - ❑ Employee + Spouse
  - ❑ Employee + Children
  - ❑ Employee + Family (Spouse and Children)

If enrolling your spouse and/or dependents in voluntary dental plan coverage, complete Section 5 of this form.

Voluntary Dental PREMIER PREMIUM Plan (Delta Dental)
- ❑ **I wish to cancel coverage**
- ❑ **No change** to my current voluntary dental plan election
- ❑ **I wish to enroll** and elect the following coverage level (choose one)
  - ❑ Employee Only
  - ❑ Employee + Spouse
  - ❑ Employee + Children
  - ❑ Employee + Family (Spouse and Children)

If enrolling your spouse and/or dependents in voluntary dental plan coverage, complete Section 5 of this form.

Vision and Voluntary Life insurance Coverage

Voluntary Vision Plan (VSP)
- ❑ **I wish to cancel coverage**
- ❑ **No change** to my current voluntary vision plan election
- ❑ **I wish to enroll** and elect the following coverage level (choose one)
  - ❑ Employee Only
  - ❑ Employee + One Dependent
  - ❑ Employee + Two or More Dependents

If enrolling your dependents in voluntary vision coverage, complete Section 5 of this form.

Voluntary Life Insurance (Sun Life)
- ❑ **I wish to cancel coverage**
- ❑ **No change** to my current voluntary life insurance plan election(s)
- ❑ **I wish to enroll** or change my current voluntary life insurance plan election(s)

If you are enrolling for the first time or you are changing your current coverage level, complete and submit the *SUN LIFE enrollment form* **with this form. Your election may require proof of your good health.**

Voluntary Short-Term Disability Insurance (Assurant)
- ❑ **I wish to cancel coverage**
- ❑ **No change** to my current voluntary short-term disability election (No additional form required)
- ❑ **I wish to enroll** or change my current voluntary short-term disability election

If you are enrolling for the first time or you are changing your current coverage level, complete and submit the *ASSURANT enrollment form* **with this form. Your election may require proof of your good health.**

Long Term Care Insurance (UNUM)
Nursing Home/Assisted Living Coverage
- ❑ **I wish to cancel coverage**
- ❑ **No change** to my current voluntary long term care insurance plan election(s)
- ❑ **I wish to enroll** or change my current voluntary long term care insurance plan election(s)

If you are enrolling for the first time or you are changing your current coverage level, complete and submit the *UNUM enrollment form* **with this form. Your election may require proof of your good health.**

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4 ELECT YOUR FLEXIBLE SPENDING ACCOUNT PLAN CONTRIBUTION

If you choose to participate in the Medical Expense Reimbursement Account and/or Child and Dependent Care Flexible Spending Account, the IRS requires you to submit a new election form each year. Indicate your elections below.

Medical Expense Reimbursement Account

- ❑ **I do not want to contribute** for 2011/12
- ❑ **I want to contribute** for 2011/12

Flexible spending account form required annually.

Child and Dependent Care Flexible Spending Account

- ❑ **I do not want to contribute** for 2011/12
- ❑ **I want to contribute** for 2011/12

Flexible spending account form required annually.

5 ADD/DROP/CHANGE COVERAGE FOR YOUR DEPENDENTS

Complete the information below if you wish to add, drop, or change medical, dental, and/or voluntary vision coverage for your eligible dependents.

Relationship	Name (First, MI, Last)	Social Security Number	Gender (M/F)	Birthdate (MM/DD/YYYY)	Medical (Check box to add or drop coverage)	Dental (Check box to add or drop coverage)	VSP (Check box to add or drop coverage)
					❑ Add ❑ Drop	❑ Add ❑ Drop	❑ Add ❑ Drop
					❑ Add ❑ Drop	❑ Add ❑ Drop	❑ Add ❑ Drop
					❑ Add ❑ Drop	❑ Add ❑ Drop	❑ Add ❑ Drop
					❑ Add ❑ Drop	❑ Add ❑ Drop	❑ Add ❑ Drop
					❑ Add ❑ Drop	❑ Add ❑ Drop	❑ Add ❑ Drop
					❑ Add ❑ Drop	❑ Add ❑ Drop	❑ Add ❑ Drop
					❑ Add ❑ Drop	❑ Add ❑ Drop	❑ Add ❑ Drop

6 DESIGNATE/CHANGE YOUR BASIC LIFE INSURANCE BENEFICIARY

The District provides eligible employees with basic life insurance coverage in the amount of $50,000. You must designate who is to receive the payment from this benefit. Your beneficiary must be at least 18 years of age.

Last Name *(Primary Beneficiary)* **First Name** **MI** **Relationship**

Social Security Number **Address**

Last Name *(Secondary Beneficiary)* **First Name** **MI** **Relationship**

Social Security Number **Address**

7 WAIVER OF INSURANCE AUTHORIZATION (complete this section ONLY if you are waiving medical coverage)

If you wish to decline medical insurance during the Open Enrollment period, you must indicate your agreement to the following:

(1) I have been given an opportunity to apply for the medical insurance offered by my employer, for which I am eligible, and decided not to accept the offer for coverage because I have other medical coverage.

(2) I understand that my election to waive group insurance coverage excludes me from receiving any of the District contribution. I will, however, be provided with basic life insurance coverage.

(3) I understand that I cannot change my election outside of the annual Open Enrollment period unless I experience a qualified life status change. In the event I experience a qualified life status change, I may change my election under the Group's Cafeteria Plan within 31 days of the event. My new election must be consistent with the life status change. Qualified life status changes are defined in detail in the *Benefits Guide*.

I have read and understand the above statements and have attached proof of my other medical coverage to this Benefit Election/Enrollment Form.

Employee Signature **Date**

8 SIGNATURE AND AUTHORIZATION

I understand and agree to the following:

- All required forms must be submitted in addition to the Benefit Election/Enrollment Form.
- If enrollment forms are not submitted within the required deadline, I will not be eligible to enroll until the next enrollment period.
- Upon selection, I may not change plans until the next open enrollment unless there is a qualifying family status change.
- Eligible deductions will be taken on a before-tax basis with all other deductions taken after tax.

I, on behalf of myself and my dependents, authorize any insurance company, HMO, Employer, Physician, Healthcare Professional, Hospital, Clinic or other medical facility to release all records pertaining to medical history, physical or mental condition, consultations and all information regarding benefits to which I may be entitled, to an agent or representative of all health plans listed above.

Employee Signature **Date**