RED CLAY CONSOLIDATED SCHOOL DISTRICT

BENEFIT ENROLLMENT FORM

PERSONAL INFORMATION

EMPLOYEE NAME (AS IT APPPEARS ON SOCIAL SECURITY CARD)	DOB	SOCIAL SECURITY NO.	EMPL ID #	HIRE DATE

District Medical Credit applied on rates below. Additional flex credit of up to $80 per paycheck for employees working 30 hours or more week. Any unused credits are forfeited. Rates on form are bi-weekly paycheck amounts.

Benefits begin the first of the month following your date of employment for employees working 30 hours or more per week.

Effective Date:

Group Health Insurance Plan (GHIP)

Coverage Level	EMPLOYEE ONLY	EMP & SPOUSE	EMP & CHILD(REN)	EMP & FAMILY
Highmark Delaware BCBS First State Basic Plan	◯ $0.00	◯ $0.00	◯ $0.00	◯ $0.00
Aetna CDH Gold Plan	◯ $0.00	◯ $12.24	◯ $0.00	◯ $5.11
Aetna HMO Plan	◯ $6.88	◯ $31.02	◯ $12.33	◯ $27.27
Highmark Delaware BCBS Comprehensive PPO Plan	◯ $50.64	◯ $120.67	◯ $80.19	◯ $139.51
	◯ WAIVE			

Effective Date:

Cigna Dental Insurance

Coverage Level		EMPLOYEE ONLY	EMP & SPOUSE	EMP & CHILD(REN)	EMP & FAMILY
	◯ WAIVE	◯ $36.85	◯ $52.08	◯ $65.93	◯ $72.18

VBA Vision Insurance

Coverage Level		EMPLOYEE ONLY	EMP & SPOUSE	EMP & CHILD(REN)	EMP & FAMILY
	◯ WAIVE	◯ $5.22	◯ $9.91	◯ $9.25	◯ $13.81

Prudential Life and ADD Insurance

Calculating the Cost

Annual Salary x 1.5, round up to next $500 = Benefit Amount
Benefit Amount x .00138= Annual Cost
Annual Cost /24 (Number of Pays) = Cost Per Paycheck

COST: $_____ ◯ **ENROLL** ◯ **WAIVE**

Long Term Disability Buy Up Plan

Calculating the Cost

Annual Salary x .00133 = Annual Premium
Annual Premium / 24 (Number of Pays) = Cost

COST: $_____ ◯ **ENROLL** ◯ **WAIVE**

IMPORTANT NOTICE REGARDING SPOUSAL COORDINATION OF BENEFITS (SCOB)

If you have selected either an "Employee & Spouse or "Family" level for your health care benefit on page one of this form, you **MUST** complete the electronic Spousal Coordination of Benefits Form upon initial enrollment, anytime enrollment or insurance status changes and each year during Open Enrollment.

SCOB POLICY: The Spousal Coordination of Benefits Policy can be found at:

https://dhr.delaware.gov/benefits/cob/education.shtml

Please provide a copy of your marriage certificate and your spouse's Social Security card.

(AS IT APPEARS ON SOCIAL SECURITY CARD) SPOUSE'S NAME	SOCIAL SECURITY NO.	DOB	GENDER

Does your spouse work for a State of Delaware agency? ◯ YES ◯ NO

Please provide a copy of your dependent's birth certificate and Social Security card.

Dependent Information

(AS IT APPEARS ON SOCIAL SECURITY CARD) DEPENDENT NAME	DOB	SOCIAL SECURITY NO.	GENDER	RELATIONSHIP	PCP ID# (For Aetna HMO ONLY)

CERTIFICATION EMPLOYEE MUST SIGN AND DATE

By my signature below, I hereby certify the benefit elections made on this form are my choice and I have completed the required forms necessary to enroll in the benefit elections chosen. I understand that, by completing and signing the required forms, I am making a binding election with regard to my benefits for the current plan year and unless I have a permissible family status changes as defined by the Internal Revenue Service, or I terminate employment with the State of Delaware.

SIGNATURE _____ **DATE** _____

Benefits Worksheet

District Dental Insurance	Cost	
Employee Only	$ 36.85	
Employee and Spouse	$ 52.08	
Employee and Child(ren)	$ 65.93	
Family	$ 72.18	**Subtotal:**

District Vision Insurance	Cost	
Employee Only	$ 5.22	
Employee and Spouse	$ 9.91	
Employee and Child(ren)	$ 9.25	
Family	$ 13.81	**Subtotal**

District Life Insurance

Calculation

Annual base salary x 1.5. Round up to the next $500 for Benefit amount.

Benefit amount x .00138 = annual premium/24 = Pay Paycheck Cost

Subtotal:

District Long Term Disability Buy Up Plan

Annual Salary X .00133 = Annual Premium/24 = Cost per Paycheck

Subtotal:

Group Health Insurance

Rates are on the benefits enrollment form and based on level of coverage and plan.

Subtotal:

Flex Credit

Flex Credits- Deduct from Subtotal

Full Time Employee- Up to $80.00

Half Time Employee- Up to $35.00

Quarter Time Employee - Up to $17.50

Subtract Credit: ( )

This is the amount you will pay each paycheck. **Total**

How to Complete the Benefit Enrollment Form

Personal Information

All Fields are required. Please list name exactly as it appears on your social security card. Enter date of birth in MMDDYYYY format in the DOB field. Enter social security number as it appears on the official social security card in the SSN field. Enter your employee ID number in the EMPLID# field. If you do not know your employee ID number, the HR/Benefits Office can provide you with this information.

Health Insurance Elections

To enroll/waive coverage in the State's Group Health Insurance Plan (GHIP), check the corresponding box to the level of coverage desired, or check the WAIVE box. **Please note**: this is the amount you will pay each paycheck effective the first of the following month **after** your date of hire.

Dental Insurance Elections

To enroll/waive coverage in the District's Dental Insurance Plan, check the corresponding box for the level of coverage desired, i.e. Employee Only, Employee & Spouse, Employee & Child(ren), or Family plan, or check mark the WAIVE box.

Vision Insurance Elections

To enroll/waive coverage in the District's Dental Insurance Plan, check the corresponding box to the level of coverage desired, i.e. Employee Only, Employee & Spouse, Employee & Child(ren), or Family plan, or place a check mark in the WAIVE box.

District's Group Life Insurance

To enroll/waive coverage in the District's Group Life Insurance Plan through Prudential, check the ENROLL/WAIVE Box. If you are having difficulties calculating the premium amount, please contact the Benefits Office.

District's Long Term Disability Buy Up Plan

To enroll/waive coverage in the District's Long Term Disability Buy Up Plan through The Hartford, check the ENROLL/WAIVE Box. If you are having difficulties calculating the premium amount, please contact the Benefits Office.

Employer Information for Spouse

If you are enrolling your spouse, indicate if your spouse is an active employee for the State of Delaware. List the agency/ department of your spouse's employer, and your spouse's date of birth as MMDDYYYY format. Please refer to the State of Delaware's Spousal Coordination of Benefits policy to determine if your spouse is eligible for medical coverage under this plan.

Dependent Information

All fields are required. List all dependent information for spouse, children, step children, adoptive children, dependent children or any qualified dependent you plan to enroll in medical, dental and vision benefits.

Signature and Date are required to authorize the benefits office to complete enrollment.