

**PENNSBURY SCHOOL DISTRICT  
SUPPORT STAFF OPEN ENROLLMENT FORM (21 PAYS) – BENEFIT PERIOD 07/01/2023 to 6/30/2024**

Employee Name: \_\_\_\_\_

EID#: \_\_\_\_\_

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.

I am electing Medical and/or RX coverage

Waiving Medical and/or RX coverage – *I understand that I need to complete the Waiver form to receive the stipend.*

Medical Plans:	Single	Parent/Child	Parent/Children	Employee/Spouse	Family
PPO 20/40	<input type="checkbox"/> \$ 42.00	<input type="checkbox"/> \$ 64.98	<input type="checkbox"/> \$ 91.63	<input type="checkbox"/> \$ 96.93	<input type="checkbox"/> \$ 124.74
PPO 10/20	<input type="checkbox"/> \$ 58.91	<input type="checkbox"/> \$ 90.72	<input type="checkbox"/> \$ 128.41	<input type="checkbox"/> \$ 135.86	<input type="checkbox"/> \$ 174.51
QPOS 30/40 <b>Primary Care</b> <b>Physician #</b> _____	<input type="checkbox"/> \$ 35.94	<input type="checkbox"/> \$ 55.80	<input type="checkbox"/> \$ 78.44	<input type="checkbox"/> \$ 82.98	<input type="checkbox"/> \$ 106.95

Prescription Plan:	Single	Parent/Child	Parent/Children	Employee/Spouse	Family
RX 15/30/50	<input type="checkbox"/> \$10.77	<input type="checkbox"/> \$ 16.30	<input type="checkbox"/> \$ 23.43	<input type="checkbox"/> \$ 24.79	<input type="checkbox"/> \$ 31.61

I am electing Dental coverage

Waiving Dental coverage

Dental Plans:	Single	Parent/Child	Parent/Children	Employee/Spouse	Family
UCCI Dental FLEX (PPO)	<input type="checkbox"/> \$ 2.06	<input type="checkbox"/> \$ 5.67	<input type="checkbox"/> \$ 5.67	<input type="checkbox"/> \$ 5.67	<input type="checkbox"/> \$ 5.67
UCCI Dental PLUS (DHMO)	<input type="checkbox"/> \$ 1.66	<input type="checkbox"/> \$ 4.79	<input type="checkbox"/> \$ 4.79	<input type="checkbox"/> \$ 4.79	<input type="checkbox"/> \$ 4.79
Delta Dental Premier Plan	<input type="checkbox"/> \$ 7.05	<input type="checkbox"/> \$17.58	<input type="checkbox"/> \$17.58	<input type="checkbox"/> \$17.58	<input type="checkbox"/> \$17.58

Dependents:	Name	Social Security Number	Birth Date	Sex
Spouse	_____	_____	_____	_____
Dependent	_____	_____	_____	_____
Dependent	_____	_____	_____	_____
Dependent	_____	_____	_____	_____

**Authorization:**

I authorize the above selections and pre-tax contributions listed on this form until 6/30/2024. 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.