PENNSBURY SCHOOL DISTRICT
SUPPORT STAFF
BENEFIT ENROLLMENT FORM (*26 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	☐ $ 33.92	☐ $ 52.48	☐ $ 74.00	☐ $ 78.29	☐ $100.75
PPO 10/20	☐ $ 47.58	☐ $ 73.27	☐ $103.72	☐ $109.73	☐ $140.95
QPOS 30/40 Primary Care Physician # _____	☐ $ 29.03	☐ $ 45.07	☐ $ 63.35	☐ $ 67.02	☐ $ 86.38

Prescription Plan:	**Single**	**Parent/Child**	**Parent/Children**	**Employee/Spouse**	**Family**
RX 15/30/50	☐ $ 8.70	☐ $ 13.16	☐ $ 18.92	☐ $ 20.02	☐ $ 25.53

☐ **I am electing Dental coverage**
☐ **Waiving Dental coverage**

Dental Plans:	**Single**	**Parent/Child**	**Parent/Children**	**Employee/Spouse**	**Family**
UCCI Dental FLEX (PPO)	☐ $ 1.67	☐ $ 4.58	☐ $ 4.58	☐ $ 4.58	☐ $ 4.58
UCCI Dental PLUS (DHMO)	☐ $ 1.34	☐ $ 3.87	☐ $ 3.87	☐ $ 3.87	☐ $ 3.87
Delta Dental Premier Plan	☐ $ 5.69	☐ $ 14.20	☐ $ 14.20	☐ $ 14.20	☐ $ 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 6/30/2024. 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.