PENNSBURY SCHOOL DISTRICT
TRANSPORTATION DEPT. ENROLLMENT FORM – 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 the pay periods 9/15/2023 through 6/21/2024 for the benefit period 7/1/23 through 6/30/24.

☐ **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	☐ $ 42.00	☐ $ 64.98	☐ $ 91.63	☐ $ 96.93	☐ $ 124.74
PPO 10/20	☐ $ 58.91	☐ $ 90.72	☐ $128.41	☐ $135.86	☐ $ 174.51
QPOS 30/40 Primary Care Physician # _____	☐ $ 35.94	☐ $ 55.80	☐ $ 78.44	☐ $ 82.98	☐ $ 106.95

Prescription Plan:	**Single**	**Parent/Child**	**Parent/Children**	**Employee/Spouse**	**Family**
RX 15/30/50	☐ $10.77	☐ $ 16.30	☐ $ 23.43	☐ $ 24.79	☐ $ 31.61

☐ **I am electing Dental coverage**

☐ **Waiving Dental coverage**

Dental Plans:	**Single**	**Parent/Child**	**Parent/Children**	**Employee/Spouse**	**Family**
UCCI Dental FLEX (PPO)	☐ $ 2.06	☐ $ 5.67	☐ $ 5.67	☐ $ 5.67	☐ $ 5.67
UCCI Dental PLUS (DHMO)	☐ $ 1.66	☐ $ 4.79	☐ $ 4.79	☐ $ 4.79	☐ $ 4.79
Delta Dental Premier Plan	☐ $ 7.05	☐ $17.58	☐ $17.58	☐ $17.58	☐ $17.58

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.