☐ *New Enrollment* ☐ *Waiver* ☐ *Change:* *Please check off reason to right*

- ☐ *Termination of Employment*
- ☐ *Marriage (Add Spouse)*
- ☐ *Divorce (Delete Spouse)*
- ☐ *Add Dependent*
- ☐ *Delete Dependent*
- ☐ *Other*_____

EMAIL FORM TO: lisa.jones@motsd.org

MOUNT OLIVE SCHOOL DISTRICT
"Ready for what comes next"

EMPLOYEE BENEFITS
2020 WORKSHEET (20 PAY PERIOD)
D15

The District and I hereby agree that I have 30 days to elect Medical, Prescription, and Dental coverage and that my compensation will be reduced, on a pre-tax basis, as required by P.L. Chapter 78 for each pay period during the plan year (or during such portion of the year as remains after the date of this agreement).

Please check off your choices for 2020/2021

Employee Name: _____ Male/Female: _____

Address: _____ City: _____ Zip: _____

SSN: _____ Date of Birth: _____

Home Phone # : _____ Date of Hire: _____

Annual Salary: _____

If you are enrolling dependents on any employee benefits or WAIVER, please complete below.

Spouse: _____ **M/F** ____ Spouse SSN: _____ Spouse DOB: _____

Child : _____ **M/F** ____ Child SSN: _____ Child DOB: _____

Child : _____ **M/F** ____ Child SSN: _____ Child DOB: _____

Child : _____ **M/F** ____ Child SSN: _____ Child DOB: _____

IMPORTANT PROVISIONS:

ELECTION / CHANGE

I cannot change or revoke these healthcare choices at any time during the plan year unless I have a change in family status (including marriage, divorce, death of a spouse or child, birth or adoption of a child, termination or commencement of employment of a spouse, or such other events as the Plan Administrator determines will permit a change or revocation of an election). Open Enrollment will occur annually and I will be able to make changes during that time. In addition, the worksheet is not a guarantee of coverage and all plan details are located in the Benefits Guide.

MEDICAL PLAN WAIVER OF COVERAGE

Eligible employees have the choice to waive health coverage (medical, prescription, and/or dental insurance) as long as the employee certifies that he/she has other medical coverage. Each school year, eligible employees may choose to "opt-out" of the district's insurance benefits. Employees choosing to "opt-out" will be required to sign this release indicating that their spouse and/or dependents are covered under another health benefit program. Employees shall be told how to re-enroll in health benefits if needed, and members are responsible for informing the Business Administrator, in writing, of any changes in circumstances regarding health benefits. This applies to new hires after July 1st and any employment termination that is effective prior to June 30th. For the 2020/2021 calendar year, the Board shall pay "opt-out" at the negotiated amount.

Type of coverage I am entitled to: ☐ Single ☐ EE/Sp ☐ EE/Child(ren) ☐ Family

For any benefits I am waiving, I recognize the following criteria for re-entry to the insurance program:

1. Employees and their family members have the option to waive or re-enter the health insurance programs by completing an enrollment application during the annual open enrollment period.
2. The decision to waive coverage cannot change until the next July 1st annual open enrollment period. Since most employees electing to waive coverage will be doing so because they have coverage through their spouse, a "hardship provision" for re-entry is available. This provision allows employees and family members, to re-enter the program, an on immediate basis, without the necessity of health questionnaires. The provision allows for re-entry only in the following situations which result in the loss of coverage through a spouse.

* Termination of Employment
* Divorce (copy of decree required)
* Legal Separation (copy of decree required)
* Death (copy of certificate required)
* Group Contract / Policy Terminated
* Military Discharge (Form DD214 required)

Please Note: To be eligible for the "opt-out" waiver-election, proof of alternative coverage *(copy of current health insurance ID card, etc.)* must accompany this form.

	Employee	Employee & Spouse	Employee & Child(ren)	Family	Waiver
Medical/RX Direct 15	☐	☐	☐	☐	☐ Waiver

DIRECT 15 MEDICAL/RX - 20 PAY PERIODS

Salary	Employee	Employee/Spouse	Employee/Child(ren)	Employee/ Family
less than 20,000	$30.29	$47.43	$34.42	$51.02
20,000-24,999.99	$37.02	$47.43	$34.42	$51.02
25,000-29,999.99	$50.48	$60.98	$44.25	$68.02
30,000-34,999.99	$67.31	$81.31	$59.01	$85.03
35,000-39,999.99	$74.04	$94.86	$68.84	$102.03
40,000-44,999.99	$80.77	$108.41	$78.67	$119.04
45,000-49,999.99	$94.24	$135.52	$98.34	$153.05
50,000-54,999.99	$134.62	$203.28	$147.52	$204.06
55,000-59,999.99	$154.82	$230.38	$167.18	$238.07
60,000-64,999.99	$181.74	$284.59	$206.52	$289.09
65,000-69,999.99	$195.21	$311.69	$226.19	$323.10
70,000-74,999.99	$215.40	$352.35	$255.69	$374.11
75,000-79,999.99	$222.13	$365.90	$265.53	$391.12
80,000-84,999.99	$228.86	$379.45	$275.36	$408.12
85,000-89,999.99	$228.86	$406.55	$295.03	$442.13
90,000-94,999.99	$228.86	$406.55	$295.03	$476.14
95,000-99,999.99	$235.59	$406.55	$295.03	$493.15
100,000-109,999.99	$235.59	$474.31	$344.20	$544.16
110,000 and over	$235.59	$474.31	$344.20	$595.18

*If you have other medical coverage, please write it here: _____

DeltaCare DHMO USA	☐	☐	☐	☐	☐ Waiver

DELTA DENTAL DHMO - 20 PAY PERIODS

Salary	Employee	Employee/Spouse	Employee/Child(ren)	Employee/ Family
less than 20,000	$0.47	$0.71	$0.69	$0.89
20,000-24,999.99	$0.58	$0.71	$0.69	$0.89
25,000-29,999.99	$0.78	$0.91	$0.89	$1.18
30,000-34,999.99	$1.05	$1.21	$1.19	$1.48
35,000-39,999.99	$1.15	$1.41	$1.39	$1.77
40,000-44,999.99	$1.25	$1.62	$1.59	$2.07
45,000-49,999.99	$1.46	$2.02	$1.98	$2.66
50,000-54,999.99	$2.09	$3.03	$2.98	$3.55
55,000-59,999.99	$2.41	$3.43	$3.37	$4.14
60,000-64,999.99	$2.82	$4.24	$4.17	$5.03
65,000-69,999.99	$3.03	$4.65	$4.56	$5.62
70,000-74,999.99	$3.35	$5.25	$5.16	$6.51
75,000-79,999.99	$3.45	$5.45	$5.36	$6.80
80,000-84,999.99	$3.56	$5.66	$5.56	$7.10
85,000-89,999.99	$3.56	$6.06	$5.95	$7.69
90,000-94,999.99	$3.56	$6.06	$5.95	$8.28
95,000-99,999.99	$3.66	$6.06	$5.95	$8.58
100,000-109,999.99	$3.66	$7.07	$6.94	$9.46
110,000 and over	$3.66	$7.07	$6.94	$10.35

* If you elect the DHMO, please write your preferred dentist's name here: _____

Dental PPO + Premier	☐	☐	☐	☐

DELTA PPO + PREMIER - 20 PAY PERIODS

Salary	Employee	Employee/Spouse	Employee/Child(ren)	Employee/ Family
less than 20,000	$1.02	$1.79	$1.63	$2.42
20,000-24,999.99	$1.25	$1.79	$1.63	$2.42
25,000-29,999.99	$1.71	$2.31	$2.10	$3.22
30,000-34,999.99	$2.27	$3.08	$2.80	$4.03
35,000-39,999.99	$2.50	$3.59	$3.26	$4.83
40,000-44,999.99	$2.73	$4.10	$3.73	$5.64
45,000-49,999.99	$3.18	$5.13	$4.66	$7.25
50,000-54,999.99	$4.55	$7.69	$6.99	$9.67
55,000-59,999.99	$5.23	$8.71	$7.92	$11.28
60,000-64,999.99	$6.14	$10.77	$9.78	$13.69
65,000-69,999.99	$6.59	$11.79	$10.71	$15.30
70,000-74,999.99	$7.27	$13.33	$12.11	$17.72
75,000-79,999.99	$7.50	$13.84	$12.58	$18.53
80,000-84,999.99	$7.73	$14.35	$13.04	$19.33
85,000-89,999.99	$7.73	$15.38	$13.98	$20.94
90,000-94,999.99	$7.73	$15.38	$13.98	$22.55
95,000-99,999.99	$7.96	$15.38	$13.98	$23.36
100,000-109,999.99	$7.96	$17.94	$16.30	$25.77
110,000 and over	$7.96	$17.94	$16.30	$28.19

	Employee	Employee & Spouse	Employee & Child(ren)	Family	Waiver
Vision	(RATES BELOW ARE ON A 20 PAY PERIOD BASIS)				
	$3.00	$3.60	$3.60	$3.60	Waiver

New Benefit!
Voluntary Life

Employee	Spouse	Child	Family	Waiver
			■	

As an employee of Mount Olive School District, you are now eligible to purchase in increments $10,000 up to $500,000. $150,000 is available with no medical questions. If you enroll, you can also purchase for your spouse $5,000 increments up to $35,000 with no medical questions and for your child $2,000 increments up to $10,000 with no medical questions.

For additional insurance amounts, please refer to the Benefits Guide for the health questionnaire that will require completion and submitted for review.

Employee Elected Amount _____ Premium _____
Spouse Elected Amount _____ Premium _____
Child Elected Amount _____ Premium _____

	Employee & Spouse Rate per $1,000 by Pay Period*	
Employee Age	24 PP	20 PP
Under 25	$ 0.033	$ 0.040
25-29	$ 0.033	$ 0.040
30-34	$ 0.038	$ 0.046
35-39	$ 0.043	$ 0.052
40-44	$ 0.058	$ 0.070
45-49	$ 0.083	$ 0.100
50-54	$ 0.123	$ 0.148
55-59	$ 0.223	$ 0.268
60-64	$ 0.338	$ 0.406
65-69	$ 0.643	$ 0.772
70-74	$ 1.038	$ 1.246
75+	$ 1.038	$ 1.246
Child/(ren)**	$ 0.063	$ 0.076

Spouse rate is based on Employee's age
**Same rate regardless of the amount of children*

Example:
45 year old employee elects $150,000 coverage

	24PP	20PP
Coverage amount	$150,000	$150,000
Rate multipler (/$1,000)	150	150
45 year old Rate:	$ 0.083	$ 0.100
Pay Period Premium:	$ 12.45	$ 14.94

New Benefit!
Critical Illness

Employee	Spouse	Child	N/A	Waiver
			■	

As an employee of Mount Olive School District, you are now eligible to purchase critical illness insurance that provides a cash benefit in the event of a serious diagnosis. You can elect a $5,000 or $10,000 benefit that is guarantee issued. Examples of coverage include heart attack, stroke, cancer, end stage renal and genetic disorders. The cash received can help supplement deductibles, copayments, transportation expenses and lodging.

VOLUNTARY CRITICAL ILLNESS EMPLOYEE OR SPOUSE PREMIUM RATES (20 PAYROLL DEDUCTIONS PER YEAR)		
Age	**$5,000**	**$10,000**
0 - 29	$0.78	$1.56
30 - 39	$1.38	$2.76
40 - 49	$3.03	$6.06
50 - 59	$6.18	$12.36
60 - 69	$12.66	$25.32

Child dependent coverage is offered at no additional cost.

Benefit Amount _____ (Employee) _____ (Spouse)

Per Pay Cost _____ (Employee) _____ (Spouse)

Example: 40 year old employee elects $5,000 of Critical Illness for themselves.
The Per Pay Cost will be $3.03

New Benefit!
Voluntary Accident

(RATES BELOW ARE ON A 20 PAY PERIOD BASIS)

$5.39	$8.36	$10.76	$14.17	Waiver

As an employee of Mount Olive School District, you are now eligible to purchase critical illness that provides a cash benefit in the event you get hurt or need any medical attention. Accident insurance pays you regardless of the copays and/or deductibles associated with the health plan you choose. Examples of cash provided include emergency room reimbursements of $250, hospital admissions up to $2,000 and urgent care center visits up to $150.

Employee Signature is REQUIRED for any enrollments/changes/waivers using this form

Employee Signature _____ Date _____

Print Employee Name _____ Business Administrator _____