2240 Old River Road
Ukiah, CA 95482-6156

Ph. (707) 467-5001
Fax (707) 462-0379

NICOLE H. GLENTZER
Superintendent of Schools

SERVICE EXCELLENCE INNOVATION TEAMWORK

BENEFITS & EMPLOYEE COST ENROLLMENT FORM

2023-2024 Rates

For Part-Time Employees

.5 - .84999 FTE (75% of Cap ER Paid)

FT Annual Benefit Cap is $13,629.19

Employee Name _____ **Coverage Eligibility Date If Selected** _____

	HEALTH, DENTAL & VISION **EMPLOYER PAYS 75% OF CAP**
	I agree to have my employee's share of the cost to be paid by payroll deduction and I understand that I am also responsible for an annual $1,000.00 deductible for health insurance. **12 Months (July-June) - $487.98** **11 Months (August – June)- $532.34** **DUAL ENROLLMENT** **12 Months (July-June) - $181.62** **11 Months (August – June)- $198.13**
	I do not wish to have health and dental and vision insurance. (Initial in box)

	HEALTH & DENTAL ONLY **EMPLOYER PAYS 75% OF CAP**
	I agree to have my employee's share of the cost to be paid by payroll deduction and I understand that I am also responsible for an annual $1,000.00 deductible for health insurance. **12 Months (July-June) - $465.49** **11 Months (August – June)- $507.80** **DUAL ENROLLMENT** **12 Months (July-June) - $176.00** **11 Months (August – June)- $192.00** ***Rates subject to change 10/1 of each FY**
	I do not wish to have health and dental insurance. (Initial in box)

More options on next page

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HEALTH & VISION ONLY EMPLOYER PAYS 75% OF CAP	
	I agree to have my employee's share of the cost to be paid by payroll deduction and I understand that I am also responsible for an annual $1,000.00 deductible for health insurance. **12 Months (July-June) - $397.31 11 Months (August – June)- $433.42** **DUAL ENROLLMENT** **12 Months (July-June) - $158.95 11 Months (August – June)- $173.40** ***Rates subject to change 10/1 of each FY**
	I do not wish to have health and vision insurance. (Initial in box)

VISION & DENTAL ONLY	
	I would like to select vision and dental only (no health) and I understand that due to the Employer Benefits Cap, the vision and dental benefit will not cost me anything. ***Rates subject to change 10/1 of each FY**
	I do not wish to have vision and dental insurance. (Initial in box)

Date_____Signature_____Employee ID #_____