



**Queen Creek Unified School District
2009/2010 BENEFIT ELECTION/ENROLLMENT FORM**



1 EMPLOYEE INFORMATION (you must complete this section)

Employee Last Name	First Name	MI	Social Security Number	<input type="checkbox"/> Male <input type="checkbox"/> Female
Street Address		City, State, ZIP		Birth Date
Home Phone			Work Location	
Office Use Only				
UHC Group Number: 709775		Delta Dental Group Number: 4267		Employer: QCUSD
Waive Coverage:		Coverage Effective Date:		Termination Date:
<input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Hire (Hire Date: _____) <input type="checkbox"/> Status Change (Type: _____ Date: _____)				

2 ELECT/CHANGE YOUR MEDICAL PLAN FOR 2009/2010 (Choose A, B, C or D)

- (A) I am electing to **WAIVE** medical coverage for 2009/10. (You also must complete Section 7 of this form.)
- (B) I am electing to make **NO CHANGE** to my current medical coverage for 2009/10.
- (C) I am electing to **CHANGE** my current coverage and elect the following medical plan and coverage level for 2009/10. (If you wish to cover your eligible dependents, you must also complete Section 3 of this form.) Indicate your medical plan choice election below.
- (D) I am a **NEW HIRE** and wish to enroll in medical coverage for 2009/10. Indicate plan choice below.

<p>0 UnitedHealthcare Choice Plus PPO</p> <p><u>Select Your Coverage Level</u></p> <p><input type="radio"/> Employee Only</p> <p><input type="radio"/> Employee + Spouse</p> <p><input type="radio"/> Employee + Child(ren)</p> <p><input type="radio"/> Employee + Family (Spouse & Children)</p> <p><input type="radio"/> Spousal Share Family Coverage</p>	<p>0 UnitedHealthcare Health Savings Account 1250 Plan (HSA-1250 Plan - Includes dental coverage)</p> <p><u>Select Your Coverage Level</u></p> <p><input type="radio"/> Employee Only</p> <p><input type="radio"/> Employee + Spouse</p> <p><input type="radio"/> Employee + Child</p> <p><input type="radio"/> Employee + Family (Spouse & Children)</p> <p><input type="radio"/> Spousal Share Family Coverage</p> <p>Elect Your Plan Year Voluntary HSA Contribution (optional)*</p> <p>\$_____ (Contribute up to \$1,750 if you elect employee only coverage, or \$4,700 if you elect yourself plus one or more dependent)</p> <p>Your Plan Year HSA“ Catch-Up Contribution” (employees age 55 or over only) \$_____ (Contribute up to \$1,000)</p>	<p>0 UnitedHealthcare Health Savings Account 2500 Plan (HSA-2500 Plan - Does not include dental coverage)</p> <p><u>Select Your Coverage Level</u></p> <p><input type="radio"/> Employee Only</p> <p><input type="radio"/> Employee + Spouse</p> <p><input type="radio"/> Employee + Child</p> <p><input type="radio"/> Employee + Family (Spouse & Children)</p> <p><input type="radio"/> Spousal Share Family Coverage</p> <p>Elect Your Plan Year Voluntary HSA Contribution (optional)*</p> <p>\$_____ (Contribute up to \$500 if you elect employee only coverage, \$3,450 if you elect coverage for yourself plus one or more dependents)</p> <p>Elect Your Plan Year HSA“ Catch-Up Contribution” (employees age 55 or over) \$_____ (Contribute up to \$1,000)</p>
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**New HSA enrollees will receive a form by mail from OptumHealth Bank to set up their health savings account*

3 ADD/DROP/CHANGE COVERAGE FOR YOUR DEPENDENTS

Complete the information below if you wish to add, drop, or change medical and/or voluntary vision coverage for your eligible dependents. Complete **all** columns for each dependent.

Relationship	Name (First, MI, Last)	Social Security Number <i>Must be completed for all Dependents</i>	Gender (M/F)	Birthdate (MM/DD/YYYY)	Medical (Check box to add or drop coverage)	VSP (Check box to add or drop coverage)
					<input type="checkbox"/> Add <input type="checkbox"/> Drop	<input type="checkbox"/> Add <input type="checkbox"/> Drop
					<input type="checkbox"/> Add <input type="checkbox"/> Drop	<input type="checkbox"/> Add <input type="checkbox"/> Drop
					<input type="checkbox"/> Add <input type="checkbox"/> Drop	<input type="checkbox"/> Add <input type="checkbox"/> Drop
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					<input type="checkbox"/> Add <input type="checkbox"/> Drop	<input type="checkbox"/> Add <input type="checkbox"/> Drop
					<input type="checkbox"/> Add <input type="checkbox"/> Drop	<input type="checkbox"/> Add <input type="checkbox"/> Drop

Are you or any of your dependents covered under any other group health plan? Yes No *If yes, complete the following:*

Name:	Employed By:
Employer's Address:	
SSN or Medicare Health Insurance No.:	Coverage Type: <input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> Medicare/Medicaid

4 ELECT YOUR FLEXIBLE SPENDING ACCOUNT PLAN CONTRIBUTION

If you choose to participate in the Medical Expense Reimbursement Account and/or Child and Dependent Care Flexible Spending Account, the IRS requires you to submit a new election form each year. Indicate your elections below.

Medical Expense Reimbursement Account

- I do not want to contribute** for 2009/2010
- *I want to contribute** for 2009/2010

***YOU MUST ALSO COMPLETE AND SUBMIT THE JEM RESOURCES PARTNERS FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM WITH THIS BENEFIT ELECTION FORM.**

Child and Dependent Care Flexible Spending Account

- I do not want to contribute** for 2009/2010
- *I want to contribute** for 2009/2010

***YOU ALSO MUST COMPLETE AND SUBMIT THE JEM RESOURCES PARTNERS FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM WITH THIS BENEFIT ELECTION FORM.**

5 ELECT/CHANGE YOUR VOLUNTARY BENEFIT PLAN COVERAGE

Voluntary Vision Plan (VSP)

- I wish to cancel coverage**
- No change** to my current voluntary vision plan coverage
- I wish to enroll** and elect the following coverage level (*choose one*)
- Employee Only
- Employee + One Dependent
- Employee + Two or More Dependents

IF ENROLLING DEPENDENTS IN VOLUNTARY VISION COVERAGE, YOU MUST ALSO COMPLETE SECTION 3 OF THIS FORM.

Voluntary Life Insurance (Sun Life)

- I wish to cancel coverage**
 - No change** to my current voluntary life insurance plan election(s)
 - I wish to enroll or change** my current voluntary life insurance plan election(s) (additional form required)
- TO ENROLL FOR THE FIRST TIME, INCREASE OR DECREASE YOUR CURRENT COVERAGE LEVEL, YOU MUST COMPLETE AND SUBMIT THE SUN LIFE ENROLLMENT FORM WITH THIS BENEFIT ELECTION FORM. YOUR ELECTION MAY REQUIRE PROOF OF YOUR GOOD HEALTH. SEE YOUR BENEFITS ADMINISTRATOR FOR MORE INFORMATION.

Voluntary Short-Term Disability Insurance (Assurant)

- I wish to cancel coverage**
 - No change** to my current voluntary short-term disability election (No additional form required)
 - I wish to enroll or change** my current voluntary short-term disability election
- TO ENROLL FOR THE FIRST TIME, INCREASE OR DECREASE YOUR CURRENT COVERAGE LEVEL, YOU MUST COMPLETE AND SUBMIT THE ASSURANT ENROLLMENT FORM WITH THIS BENEFIT ELECTION FORM. YOUR ELECTION MAY REQUIRE PROOF OF YOUR GOOD HEALTH. SEE YOUR BENEFITS ADMINISTRATOR FOR MORE INFORMATION.

6 DESIGNATE/CHANGE YOUR BASIC LIFE INSURANCE BENEFICIARY

The District provides eligible employees with basic life insurance coverage in the amount of \$50,000. You must designate who is to receive the payment from these benefits. Your beneficiary must be at least 18 years of age.

Primary				Percentage (Must total 100%)
Last Name:	First Name:	MI	Relationship	%
SS#				Address:
Secondary				Percentage (Must total 100%)
Last Name:	First Name:	MI	Relationship	%

7 WAIVER OF INSURANCE AUTHORIZATION (complete this section ONLY if you are waiving medical coverage)

If you wish to decline medical insurance during the Open Enrollment period, you must indicate your agreement to the following:

(1) I have been given an opportunity to apply for the medical insurance offered by my employer, for which I am eligible, and decided not to accept the offer for coverage because I have other medical coverage for (check one; proof of other insurance is required):

- Myself**
- Myself + 1 dependent**
- Myself + 2 or more dependents**

(2) I understand that my election to waive group insurance coverage excludes me from receiving any of the VSMG contribution

(3) I understand that I cannot change my election outside of the annual Open Enrollment period unless I experience a qualified life status change. In the event I experience a qualified life status change, I may change my election under the Group's Cafeteria Plan within 31 days of the event. My new election must be consistent with the life status change. Please see your Benefits Administrator if you have a question regarding Life Status Changes.

I have read and understand the above statements and have attached proof of my other medical coverage to this Benefit Election form.

Employee Signature _____

Date _____

8 SIGNATURE AND AUTHORIZATION

I understand and agree to the following:

- All required forms must be submitted in addition to the benefit election/enrollment form.
- If enrollment forms are not submitted within the required deadline, I will not be eligible to enroll until the next enrollment period.
- Upon selection, I may not change plans until the next open enrollment unless there is a qualifying family status change.
- Eligible deductions will be taken on a before-tax basis with all other deductions taken after tax.
- The district is committed to continue funding 100% of the cost of the traditional (Choice Plus) plan through the 2009-2010 school year if the rate of increase does not exceed 10% per year. I understand if I choose to stay on the traditional plan (Choice Plus) after the July 2009-2010 school year, I need to prepare to pay a portion of the premiums and/or experience a reduction in benefits.

I, on behalf of myself and my dependents, authorize any insurance company, HMO, Employer, Physician, Healthcare Professional, Hospital, Clinic or other medical facility to release all records pertaining to medical history, physical or mental condition, consultations and all information regarding benefits to which I may be entitled, to an agent or representative of all health plans listed above.

Employee Signature _____

Date _____