SADDLEBACK VALLEY UNIFIED SCHOOL DISTRICT
EMPLOYEE HEALTH INSURANCE PAYROLL DEDUCTION FORM

Last Name (Please Print)	First Name	Employee PIN	☐ Certificated ☐ Classified

Employees who elect the PPO or HMO Medical Plan will be required to pay a portion of the cost according to the rates shown below. All deductions are made on a **10-month payroll cycle**. Deductions for domestic partners must be taken on an after tax basis. Refer to General Instructions for domestic partner requirements and guidelines.

SVEA	Employee Only	Employee + 1 Dependent or domestic partner	Employee + Family (2 or more)	*PAYROLL USE ONLY* *Payroll Deduction* *Eff Date:_____* *A/D/C*	*Adj. Amount*
Blue Shield PPO	☐ $100	☐ $225	☐ $335		
Blue Shield HMO	☐ $50	☐ $75	☐ $100		
SVMTA/SVPSA					
Blue Shield PPO	☐ $120	☐ $225	☐ $335		
Blue Shield HMO	☐ $50	☐ $75	☐ $100		
CSEA – Full Time					
Blue Shield PPO	☐ $170	☐ $333	☐ $497		
Blue Shield HMO	☐ $127	☐ $245	☐ $358		
CSEA – Part Time Blue Shield HMO w/ Mental Health					
6 hours per day	☐ $127	☐ $721	☐ $1,315		
5-5.9 hours per day	☐ $159	☐ $753	☐ $1,347		
4-4.9 hours per day	☐ $318	☐ $912	☐ $1,506		

Please read: It is the policy of the District to accept payroll contributions for medical insurance benefits on a tax-free basis. This is accomplished by reducing your taxable compensation by the amount of your payroll contribution. If you do not wish to have your payroll contributions paid on a tax-free basis, indicate below:

I DO NOT elect to pay for my medical insurance benefits with a pre-tax deduction, please take my deduction on an after-tax basis ☐

NO MEDICAL BENEFIT ELECTION ☐ $0

Please Read and Sign:

I understand that I cannot change my health plan election, add a dependent or change my flexible spending account election until the next annual open enrollment period, unless I have a mid-year qualifying event or change in family status. **I confirm** that enrolled dependents are eligible based on being a legally married spouse from whom I am not legally separated and who is not a member on active duty with the Armed forces: or child (including stepchild, child of an eligible domestic partner, legally adopted child or foster child) who is less than 26 years of age, who is not covered for benefits as a District employee, and is not a member on active duty with the Armed Forces; and who has been enrolled and accepted by the District as a dependent and has maintained membership under terms of the plan. **I understand** that I must advise the Benefits Administrator of any dependents that become ineligible as a result of divorce and/or legal separation, and that failure to report ineligible dependents will result in loss of their COBRA continuation rights. In addition, I may be responsible for premiums and claim expenses paid on behalf of ineligible dependents. **I understand that I must advise the Benefits Administrator of any new dependents as the result of birth, adoption, or marriage within 31 days of the event.** Failure to notify will result in loss of coverage for that dependent until the next open enrollment period. **I confirm** I have filed a Declaration of Domestic Partnership in order to enroll a domestic partner, if applicable.

Signature_____**Date**_____

Return this form and required documentation to Benefits Department along with any applicable Enrollment or Change Form. Your enrollment will not be finalized until all required forms are completed, signed and approved by the Benefits Dept.

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