SADDLEBACK VALLEY UNIFIED SCHOOL DISTRICT
EMPLOYEE HEALTH INSURANCE PAYROLL DEDUCTION FORM
EFFECTIVE 01/01/2016

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

Employees who elect medical, behavioral health, dental and vision insurance 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**.

- Ded uctions for *registered, domestic partners* must be taken on an after tax basis. Refer to Tax Information for Registered Domestic Partners (FTB Pub 737). Check here *if you are covering a registered, Domestic Partner*: ☐
- Deductions for same sex marriages may be taken on a pre-tax basis. Check here *if you are covering a same sex spouse*: ☐

Select the appropriate contribution based on your bargaining unit and benefits election:

	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*
SVEA					
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	☐ $169	☐ $329	☐ $492		
Blue Shield HMO	☐ $64	☐ $121	☐ $176		
CSEA – Part Time Blue Shield HMO w/ Mental Health					
6 hours per day	☐ $64	☐ $895	☐ $1,726		
5-5.9 hours per day	☐ $224	☐ $1,055	☐ $1,887		
4-4.9 hours per day	☐ $448	☐ $1,279	☐ $2,111		

Please read: It is the policy of the District to accept payroll contributions for medical insurance benefits on a tax-free basis. This policy reduces 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 ☐

I AM DECLINING MEDICAL COVERAGE ☐ $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 understand that the election on my enrollment/change form will supersede any erroneous election made on this form. **I confirm** that enrolled dependents are eligible based on being a registered Domestic Partner, or 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 Department.