

**San Dieguito Union High School District
2023 Benefits Selection Form
Classified Employees
4.0-7.0 hour/day Instructional Assistants**

Employee Name: _____ Site: _____

	Medical	Dental	Vision
Spouse	_____	_____	_____
Child	_____	_____	_____
Child	_____	_____	_____
Child	_____	_____	_____
Child	_____	_____	_____

In addition to the benefits indicated on the Benefit Selection Form, enrollment form(s) must be completed and attached. **All rates are monthly (processed on September – June payroll only).**

Medical Plan		Dental Plan			
United Healthcare HMO Network 1		Delta Dental PPO			
_____ Employee Only	\$30.00	_____ Employee Only	District Paid		
_____ Employee + 1	\$965.00	_____ Employee + 1	\$60.80		
_____ Employee + Family	\$1,729.00	_____ Employee + Family	\$93.10		
United Healthcare Harmony HMO		Delta Dental DMO			
_____ Employee Only	\$30.00	_____ Employee Only	District Paid		
_____ Employee + 1	\$887.00	_____ Employee + 1	District Paid		
_____ Employee + Family	\$1,593.00	_____ Employee + Family	District Paid		
United Healthcare Alliance \$20/\$30		Vision Plan			
_____ Employee Only	\$84.00			MES	
_____ Employee + 1	\$1,045.00			_____ Employee Only	\$14.21
_____ Employee + Family	\$1,832.00	_____ Employee + 1	\$25.58		
United Healthcare PPO		_____ Employee + Family	\$36.66		
_____ Employee Only	\$769.00				
_____ Employee + 1	\$2,411.00				
_____ Employee + Family	\$3,826.00				
Cigna HMO					
_____ Employee Only	\$30.00				
_____ Employee + 1	\$1,058.00				
_____ Employee + Family	\$1,898.00				
Kaiser					
_____ Employee Only	\$30.00				
_____ Employee + 1	\$861.00				
_____ Employee + Family	\$1,551.00				

_____ **Instructional Assistant (4.0-7.0 hour/day) employee – I elect no medical coverage**

_____ **Instructional Assistant (4.0-7.0 hour/day) employee – I elect no dental coverage**

I authorize San Dieguito Union High School District to deduct from a salary warrant the balance due, if any. I understand that any cash received in the form of increased disposable income will be subject to any appropriate taxes. I understand that the purpose of this program is to allow employees to select their qualified benefits within the guideline of the Internal Revenue Code, and that I may select either cash or qualified benefits, or a combination of both after providing for my required Medical and Dental employee coverages. These required coverages cannot be revoked or changed during the plan year. I understand that the selection of an insurance benefit and the indication that a premium is to be paid does not necessarily include me in the insurance portions of this program, that the premium for the contract selected may be adjusted by the insurance company issuing the contract, and, in most instances, an application for insurance must also be completed. I understand that I waive the right to cancel coverage after the monthly premium has been deducted. All changes must be made through the District and **not** directly with the insurance carrier.

Employee Signature

Date