

**San Dieguito Union High School District
2021 Benefits Selection Form
Classified Employees (Part-time)**

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	\$908.00	_____ Employee Only	\$61.75
_____ Employee + 1	\$1,780.00	_____ Employee + 1	\$122.55
_____ Employee + Family	\$2,498.00	_____ Employee + Family	\$154.85
United Healthcare HMO Network 2		Delta Dental DMO	
_____ Employee Only	\$1,232.00	_____ Employee Only	\$57.53
_____ Employee + 1	\$2,419.00	_____ Employee + 1	\$57.53
_____ Employee + Family	\$3,397.00	_____ Employee + Family	\$57.53
United Healthcare Alliance \$20/\$30		Vision Plan	
_____ Employee Only	\$945.00	MES	
_____ Employee + 1	\$1,838.00	_____ Employee Only	\$12.26
_____ Employee + Family	\$2,570.00	_____ Employee + 1	\$22.07
United Healthcare PPO		_____ Employee + Family	\$31.63
_____ Employee Only	\$1,589.00		
_____ Employee + 1	\$3,120.00		
_____ Employee + Family	\$4,442.00		
Cigna HMO			
_____ Employee Only	\$839.00		
_____ Employee + 1	\$1,741.00		
_____ Employee + Family	\$2,479.00		
Kaiser			
_____ Employee Only	\$789.00		
_____ Employee + 1	\$1,560.00		
_____ Employee + Family	\$2,199.00		

_____ **Part-time, <50% contract, Employee – I elect no medical coverage**

_____ **Part-time, <50% contract, 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