2023-2024 Open Enrollment AUSD Election Form – Classified Employees

Employees who work 6 hours per day/30 hours per week are eligible to elect one of the below benefit packages. **Employees who work 8 hours per day/40 hours per week must make a selection below.** All coverages will be effective 10/1/2023. *Payroll deductions are not taken during the months of June and July.

Benefit Package	Employee Only	Employee + 1	Employee + 2 or More
Kaiser HMO / Delta Dental PPO / Eye Med Vision	☐No Cost	☐$72.72 per month*	☐$99.60 per month*
Kaiser DHMO / Delta Dental PPO / Eye Med Vision	☐No Cost	☐$69.41 per month*	☐$95.00 per month*
Blue Shield Save Net / Delta Dental PPO / Eye Med Vision	☐No Cost	☐$71.09 per month*	☐$97.54 per month*
Blue Shield HMO / Delta Dental PPO / Eye Med Vision	☐No Cost	☐$75.99 per month*	☐$104.50 per month*
Blue Shield PPO G20 / Delta Dental PPO / Eye Med Vision	☐No Cost	☐$77.67 per month*	☐$106.52 per month*
Blue Shield PPO G30 / Delta Dental PPO / Eye Med Vision	☐No Cost	☐$73.64 per month*	☐$101.19 per month*
Kaiser HMO / Delta Care HMO / Eye Med Vision	☐No Cost	☐$70.68 per month*	☐$97.56 per month*
Kaiser DHMO / Delta Care HMO / Eye Med Vision	☐No Cost	☐$67.37 per month*	☐$92.96 per month*
Blue Shield Save Net / Delta Care HMO / Eye Med Vision	☐No Cost	☐$69.05 per month*	☐$95.50 per month*
Blue Shield HMO / Delta Care HMO / Eye Med Vision	☐No Cost	☐$73.95 per month*	☐$102.46 per month*
Blue Shield PPO G20 / Delta Care HMO / Eye Med Vision	☐No Cost	☐$75.63 per month*	☐$104.48 per month*
Blue Shield PPO G30 / Delta Care HMO / Eye Med Vision	☐No Cost	☐$71.60 per month*	☐$99.15 per month*
Kaiser HMO / Anthem Dental PPO / Eye Med Vision	☐No Cost	☐$73.48 per month*	☐$100.36 per month*
Kaiser DHMO / Anthem Dental PPO / Eye Med Vision	☐No Cost	☐$70.17 per month*	☐$95.75 per month*
Blue Shield Save Net / Anthem Dental PPO / Eye Med Vision	☐No Cost	☐$71.85 per month*	☐$98.29 per month*
Blue Shield HMO / Anthem Dental PPO / Eye Med Vision	☐No Cost	☐$76.74 per month*	☐$105.25 per month*
Blue Shield PPO G20 / Anthem Dental PPO / Eye Med Vision	☐No Cost	☐$78.42 per month*	☐$107.27 per month*
Blue Shield PPO G30 / Anthem Dental PPO / Eye Med Vision	☐No Cost	☐$74.39 per month*	☐$101.94 per month*

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Employees working 7.25 hours per day or less may waive medical coverage. If you wish to waive medical and/or dental and vision coverage, please complete the section below. **Only one dental plan may be selected.

Benefit Plan - Check all that apply	Employee Only	Employee + 1	Employee + 2 or More
Eye Med Vision	☐No Cost	☐No Cost	☐No Cost
Delta Dental PPO**	☐No Cost	☐No Cost	☐No Cost
Delta Care HMO**	☐No Cost	☐No Cost	☐No Cost
Anthem Dental PPO	☐No Cost	☐No Cost	☐No Cost
Waive all coverage	☐No Cost	☐No Cost	☐No Cost

Please list all covered dependents below. Attach additional pages if necessary.

	Name	Gender	Relation	SSN	DOB	Coverage (check all that apply)
1						☐Medical ☐Dental ☐Vision
2						☐Medical ☐Dental ☐Vision
3						☐Medical ☐Dental ☐Vision
4						☐Medical ☐Dental ☐Vision
5						☐Medical ☐Dental ☐Vision

Read and Sign: I understand I cannot change my health plan election or covered dependents until the next annual open enrollment period, unless I have a mid-year qualifying event. I understand that such event is subject to IRS guidelines. I understand that benefit eligibility, including eligible dependents, as well as plan costs, are subject to CSEA negotiations and the provisions of the Plan Document and therefore subject to change. I agree that I will not enroll any ineligible dependents on the plan, and will notify the District immediately upon a dependent becoming ineligible, and that failure to do so may result in financial penalties and affect the District's ability to offer COBRA. I understand this election supersedes all previous elections, and authorize the District to withhold premiums from my paycheck based on my election here. Should my paycheck not have sufficient funds to cover this election, I will be responsible for submitting payment directly to the benefits department. I understand that any premiums deducted from my paycheck will be done on a pre-tax basis unless I request otherwise in writing. I also understand that deductions for a domestic partner, if I have one, will be taken on an after-tax basis per FTB Pub 737.

Employee Name: ____ Employee ID: _____________

Employee Signature: ____ Date: _____________