PHOENIX ELEMENTARY SCHOOL DISTRICT NO. 1
2023/2024 Cobra ELECTION FORM

1 EMPLOYEE INFORMATION (you must complete all sections of this form)

❑ Male
❑ Female
❑ Single
❑ Married

Last Name **First Name** **MI** **Social Security Number**

Street Address **City, State, ZIP** **Birth Date**

Home Phone **Work Phone** **Email Address**

2 ELECT YOUR MEDICAL PLAN — Select either A, B or C and who will be covered within that medical plan

A. CHOICE PLUS HDHP $3,000

- ☐ Employee Only $513.44/mo.
- ☐ Employee + 1 Dep. $1,026.89/mo.
- ☐ Employee + Family $1,216.87/mo.
- ☐ Waive (Decline)
- ☐ **HSA Employee MAX Contribution ($3,850)** $____________

(+2% admin fee to all options)

B. NARROW NETWORK DOCTORS PLAN

- ☐ Employee Only $569.15/mo.
- ☐ Employee + 1 Dependent $1,138.29/mo.
- ☐ Employee + Family $1,348.89/mo.
- ☐ Waive (Decline)

(+2% admin fee to all options)

C. CHOICE PLUS BUY-UP PLAN

- ☐ Employee Only $619.90/mo.
- ☐ Employee + 1 Dep. $1,239.80/mo.
- ☐ Employee + Family $1,469.17/mo.
- ☐ Waive (Decline)

(+2 % admin fee to all options)

Are you currently enrolled in Medicare?
❑ Yes ❑ No

❑ Check this box if you want online statements from UHC

United Health Care
Group # 927878
Website: https://www.whyuhc.com/phoenix1

3 ELECT YOUR DENTAL PLAN (ONLY SELECT 1 CHOICE)

Select Your Coverage Level

- ☐ Employee Only $35.36/mo.
- ☐ Employee + 1 Dependent $73.84/mo.
- ☐ Employee + Family $118.98/mo.
- ☐ Waive (Decline)

(+2% admin fee to all options)

Delta Dental of Arizona
Group # 04693
Member Services Phone Number: 1-800-352-6132
Website: http://www.deltadentalaz.com

4 ELECT YOUR VISION PLAN (ONLY SELECT 1 CHOICE)

Select Your Coverage Level

- ☐ Employee Only $6.19/mo.
- ☐ Employee + 1 Dependent $12.51/mo.
- ☐ Employee + Family $21.93/mo.
- ☐ Waive (Decline)

(2% admin fee to all options)

Delta Vision - EyeMed Vision Care Program
Group # 9688037
Member Services Phone Number: 866-559-5252
Website: http://www.eyemedvisioncare.com

5 ADD COVERAGE FOR YOUR DEPENDENTS

Complete the information below if you want to add medical, dental and/or vision coverage for your eligible dependents

Relationship	Name (First, MI, Last)	Social Security Number	Gender (M/F)	Birthdate (MM/DD/YYYY)	Medical (Check box to add coverage)	Dental (Check box to add coverage)	Vision (Check box to add coverage)
					θ Add θ Drop	θ Add θ Drop	θ Add θ Drop
					θ Add θ Drop	θ Add θ Drop	θ Add θ Drop
					θ Add θ Drop	θ Add θ Drop	θ Add θ Drop

6 SIGNATURE ACKNOWLEDGEMENT & AUTHORIZATION

By signing below, I acknowledge and agree to the following:

- I have received the required disclosure packet, including my rights under HIPAA and COBRA, along with the appropriate plan summaries.
- I authorize the District to make the necessary deductions from my pay to cover my cost of the above elections.
- The Dependents listed above for enrollment are qualified for coverage under the rules of the plan and I will provide the District with proof upon request.
- I understand that I cannot change my elections outside of the annual Open Enrollment period unless I experience a qualified life status change. In the event I experience a qualified life status change, I may change my elections under the Group's Cafeteria Plan within 31 days of the event. My new elections must be consistent with the life status change. Qualified life status changes are defined in the *Benefits Guide*.
- I will not be "rolled over" into any benefits at Open Enrollment for the 2024-2025 school year, with these elections/coverages terminating June 30, 2024.
- This completed form is due to the benefits office within 31 days from my hire or qualified life status change date or Open Enrollment for the 2023-2024 school year will be my next opportunity to enroll or change.
- These elections/coverages will be terminated upon my separation from the District with COBRA rights enforced.
- If I have elected to waive (decline) medical insurance for myself or Dependents, I agree to the following;
  I have been given an opportunity to apply for the medical insurance offered by my employer, for which I am eligible, and decided not to accept the offer for coverage because I have other medical coverage to satisfy ACA requirements. I understand that my election to waive group insurance coverage excludes me from receiving any of the District contribution.
  I have read and understand the above statements and will provide the District with proof of my other medical coverage on request.

Employee Signature **Date**