

WOODBIDGE TOWNSHIP SCHOOL DISTRICT
HEALTH, DENTAL, PRESCRIPTION AND VISION INSURANCE ELECTION & SALARY REDUCTION FORM
Beginning July 2011

PLEASE PRINT - ALL INFORMATION IS REQUIRED:

NAME: _____ Full SS#: _____
 STREET: _____
 CITY/STATE/ZIP: _____ HOME PHONE: _____
 DATE OF HIRE: _____ WORK LOCATION: _____

INSTRUCTIONS:

Please make a choice in each of the sections below.

Employees with less than 3 years 1 day of service may purchase family coverage at the cost listed on the back of this form.

Employees choosing Traditional Benefits contribute the cost listed on the back of this form.

Health Coverage: (Select Plan)			
_____ PPO Plan	_____ Traditional Plan	Requires premium contribution above standard payroll reduction	
Level of Coverage: (Check Level)			
_____ Single	_____ Parent/Child(ren)	_____ 2 Adults	_____ Family

Dental Coverage (Select Plan)		Level of Coverage: (Check Level)	
_____ Horizon Dental	_____ Eastern Dental DSO		
_____ Single	_____ 2 Adults		
_____ Parent/Child(ren)	_____ Family		

BeneCard Prescription Coverage		Level of Coverage: (Check Level)	
_____ Single	_____ 2 Adults		
_____ Parent/Child(ren)	_____ Family		

Vision Service Plan Vision/Optical Coverage		Level of Coverage: (Check Level)	
_____ Single	_____ Employee + Dependents		

Authorization and Agreement:

- I agree that the benefit option I have elected will remain in force until the next Open Enrollment period, unless my family or eligibility status changes.
- I hereby authorize Woodbridge Township Board of Education to reduce my earning by the required contribution on a "pre-tax" basis.
- I represent that all the information supplied on my health, dental, and vision insurance application is true and complete.

 Employee Signature Date

Completed by Insurance Department:

Standard Payroll Reduction: Single \$10.00 per pay or Employee plus spouse/family \$20.00 per pay

Other Self-pay benefits: _____ (see back of form for details)

WAIVER OPTION: Employees may waive ALL insurance benefits in exchange for a lump sum received in June at the conclusion of the school year for which the waiver applies. The waiver dollar amount will be \$5,000 for family coverage or \$2,500 for single coverage. Employees are only eligible for single rate until the completion of three years of employment.

Employees hired during the year who waive coverage will have the payment prorated. I understand that if I WAIVE coverage I must wait until the next Open Enrollment period to enroll unless my family or eligibility status changes.

If you waive coverage, do you verify that you have another source of health insurance? (circle) YES NO

I choose to waive ALL coverage for the 2011-2012 school year: YES NO

 Employee Signature Date

Beginning July 1, 2011

PAYROLL REDUCTION RATES FOR HEALTH BENEFITS

The following rates apply ONLY to employees who HAVE NOT completed 3 years 1 day of service or those choosing the Traditional Plan. Reduction is PER PAYCHECK

Traditional Plan	Employees with less than 3 year 1 day service	First year employees	Employee with more than 3 years service
Employee Only	\$36.67	\$30.56	\$36.67
Employee and Child(ren)	\$502.03	\$418.36	\$86.61
Employee and Spouse	\$683.39	\$569.50	\$105.96
Employee, Spouse and Child(ren)	\$847.64	\$706.37	\$123.56

PPO	Employees with less than 3 year 1 day service	First year employees	
Employee Only	\$0.00	\$0.00	\$0.00
Employee and Child(ren)	\$415.42	\$346.19	\$0.00
Employee and Spouse	\$577.43	\$481.20	\$0.00
Employee, Spouse and Child(ren)	\$724.08	\$603.40	\$0.00

Horizon Dental	Employees with less than 3 year 1 day service	First year employees	
Employee Only	\$0.00	\$0.00	\$0.00
Employee and Child(ren)	\$42.46	\$35.38	\$0.00
Employee and Spouse	\$42.46	\$35.38	\$0.00
Employee, Spouse and Child(ren)	\$42.46	\$35.38	\$0.00

Eastern Dental	Employees with less than 3 year 1 day service	First year employees	
Employee Only	\$0.00	\$0.00	\$0.00
Employee and Child(ren)	\$31.79	\$26.49	\$0.00
Employee and Spouse	\$12.94	\$10.79	\$0.00
Employee, Spouse and Child(ren)	\$31.79	\$26.49	\$0.00

Prescription Plan	Employees with less than 3 year 1 day service	First year employees	
Employee Only	\$0.00	\$0.00	\$0.00
Employee and Child(ren)	\$117.77	\$98.15	\$0.00
Employee and Spouse	\$117.77	\$98.15	\$0.00
Employee, Spouse and Child(ren)	\$117.77	\$98.15	\$0.00

Vision/Optical Plan (VSP)	Employees with less than 3 year 1 day service	First year employees	
Employee Only	\$0.00	\$0.00	\$0.00
Employee plus Spouse and Child(ren)	\$5.78	\$4.82	\$0.00

Employees completing 3 years 1 day of service during the 2011-2012 School Year **MUST** contact Employee Benefits to have these payroll reductions terminated and to request enrollment packets to add their family to their insurance.

Please email: nancy.alberici@woodbridge.k12.nj.us with questions.