

**BENEFIT WORKSHEET 2016/2017**

**BENEFIT CREDIT ALLOWANCE: \$9192.00**

**This worksheet and required forms must be returned to the Business Office no later than September 2, 2016.**

**Employees must select a health and dental option.**

**Employee Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Your signature above indicates that you have read the Cobra information on the back of this worksheet

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 Board Paid Life and Disability are provided at no reduction to your benefit allowance. Employee rates are the only amounts that affect the benefit allowance. All dependent premiums are the employee's responsibility.  
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**PLEASE CIRCLE THE PLANS YOU WISH TO ENROLL IN FOR THE 2016-2017 YEAR**

**HEALTH PLAN ....Anthem Blue Cross/Blue Shield HealthCare - Active Premium**

<b>CORRIDOR:</b> (circle corridor you are choosing)	Employee (monthly)	Spouse (monthly)	Child(ren) (monthly)	Spouse & Child(ren) (monthly)
<input type="checkbox"/> <b>\$500</b>	\$721.00	\$689.00	\$589.00	\$1169.00
<input type="checkbox"/> <b>\$1,000</b>	\$688.00	\$657.00	\$552.00	\$1122.00
<input type="checkbox"/> <b>\$2,000</b>	\$640.00	\$615.00	\$499.00	\$1035.00

**(KIDZ Plan)**

(Individual Child)	<input type="checkbox"/> N/A	<input type="checkbox"/> N/A	<input type="checkbox"/> \$198.50	<input type="checkbox"/> N/A
(Multiple Children)	<input type="checkbox"/> N/A	<input type="checkbox"/> N/A	<input type="checkbox"/> \$397.00	<input type="checkbox"/> N/A

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<b><u>DENTAL PLANS</u></b>	Employee (monthly)	Spouse (monthly)	Child(ren) (monthly)	Spouse & Child(ren) (monthly)
Delta Dental (Premier- PPO)	\$45.00	\$41.00	<input type="checkbox"/> \$68.00	\$109.00
Delta Dental (EPO - PPO)	\$20.00	\$14.00	<input type="checkbox"/> \$17.00	\$37.00

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**THE BENEFITS LISTED BELOW WILL BE AT THE EMPLOYEE'S OWN COST**

**VISION CARE** (optional) -- application required **ONLY** if you choose to participate.

UHC Vision	Employee (monthly)	Spouse/Child(ren) (monthly)
	<input type="checkbox"/> \$5.79/month	<input type="checkbox"/> \$16.76/month

**LIFE INSURANCE** (optional) **Additional** **Dependent**

The Hartford	50% Annual Salary .272 per \$1000	<input type="checkbox"/> 1x Annual Salary .272 per \$1000	<input type="checkbox"/> 2x Annual Salary .272 per \$1000	<input type="checkbox"/> 3x Annual Salary .272 per \$1000	Spouse/\$7500-Child/\$2000 \$2.00 per month
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Maximum supplemental is \$250,000.

**PRE-PAID LEGAL PROGRAM** (optional) – application required **ONLY** if you choose to participate.

Hyatt Legal  \$14.00/month (includes spouse and legal dependents)

**SECTION 125** (application is necessary each year. If participating, there is a \$4.75 per month fee).

**Discovery Benefits:**  Medical/Dental Expenses (Un-reimbursed)  Dependent Care Expenses  
 (Benefit Card) (Child Care Reimbursement)

**(All dependent premiums will be automatically tax-sheltered at no charge to employee. No form is needed).**