Cedar Grove - Belgium School District

JULY 2021 COVERAGE ELECTION/WAIVER FORM

Please complete to indicate your elections/waivers for medical, dental, STD, LTD Life, Voluntary Life coverage, and/or Accident and Vision.

Medical – GWT UHC Insurance

I elect ☐ **or** waive ☐ coverage under the Medical plan through GWT UHC for:
☐ Self ☐ Family

2021 Employee 24 week contribution rates: GWT UHC

Plan 1-Base	Plan 2 – High Deductible
Single: $ 22.80	Single: $ 11.59
Family: $ 151.30	Family: $ 73.65
$2K/$4K Deductible	**$4K/$8K Deductible**
80% coinsurance	**100% coinsurance**

***Note: These rates are for 1.0 FTE; pro-rated rates will be determined for those who are less than 1.0 FTE.**

		Social Security #	Birthdate #
Self:	____________________	______________	____________
Dependents:	____________________	______________	____________
	____________________	______________	____________
	____________________	______________	____________
	____________________	______________	____________
	____________________	______________	____________

I elect to waive insurance and choose $1,200 cash in lieu. ☐
Handbook reads: "Beginning the 2014-2015 school year, this provision would not apply to newly hired employees whose health coverage would continue as a dependent of any other employee on the CGB School District's health plan. The District reserves the right to revise or terminate this benefit at any time."

Dental – Delta Dental

I elect ☐ **or** waive ☐ coverage under the Dental plan through Delta Dental for:

☐ Self ☐ Family

2021 Employee contribution rates: Family $ 8.57 Employee $ 1.11
***Note: These rates are for 1.0 FTE; pro-rated rates will be determined for those who are less than 1.0 FTE.**

Mutual of Omaha

Life/STD/LTD (100% paid by CGBSD)

I elect ☒ coverage under the Basic Life, STD, and LTD policies through Mutual of Omaha

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Voluntary Life (See MOO enrollment form for rates)

I elect ☐ **or** waive ☐ coverage under the Voluntary Life plan through Mutual of Omaha for:

☐ Self ☐ Spouse ☐ Dependent

United Healthcare:

Accident (See UHC enrollment form for rates)

I elect ☐ **or** waive ☐ coverage under the Voluntary Accident plan through United Healthcare for:

☐ Self ☐ Employee & spouse ☐ Employee & Children ☐ Family

Vision (See UHC enrollment form for rates)

I elect ☐ **or** waive ☐ coverage under the Vision plan through United Healthcare for:

☐ Self ☐ Employee & spouse ☐ Employee & Children ☐ Family

Consequences of Waiver: I understand that by waiving any coverage above, I forfeit my right to coverage. I also understand that, if I apply later, I will be considered a late enrollee. I further understand that late enrollees may be declined from coverage, excluded from coverage for a period of time, or subject to pre-existing limitations.

Signature ____ Date ________________________

Print Name ____