Coweta County School System

COWETA COMMITTED TO STUDENT SUCCESS

Cafeteria Plan Election & Enrollment Form

Employee Name	☐ Female ☐ Male	☐ Married ☐ Single	Birthdate (Mo. Day, Yr.)	Hire Date (Mo. Day, Yr.)
Address	EE ID	Social Security Number		Effective Date
City State Zip	Occupation			Annual Earnings $
Paymode ☐ Monthly ☐ Bi-Weekly	Home/Cell Phone ( )	Email Address		Plan Year End
☐ New Employee or Annual Enrollment	Change Due To: ☐ Marriage ☐ Birth ☐ Death ☐ Divorce ☐ Adoption ☐ Terminated ☐ Name Change ☐ Other _______	Actively at work? ☐ yes ☐ no		☐ COBRA ☐ Retiree

► Beneficiary for Basic & Supplemental Group Life Insurance	Relationship

I ELECT TO RECEIVE THE FOLLOWING COVERAGES UNDER THE CAFETERIA PLAN ON A "PRE-TAX" BASIS:

I hereby agree that my cash compensation will be reduced by the amounts set forth below for each pay period during the plan year (or during such portion of the plan year that remains after the date of this agreement). On this or the appropriate form(s), I have enrolled for the below benefits.

Coverage				Mo. Deduction
State Health Benefit Plan (Must complete SHBP enrollment online) *BCBS = BlueCross, UHC= United Healthcare*				
☐ Single ☐ Employee + Children ☐ Employee + Spouse ☐ Family	Tobacco Surcharge ☐ Yes ☐ No	☐ HRA Gold – BCBS ☐ HRA Silver – BCBS ☐ HRA Bronze – BCBS ☐ HMO – BCBS ☐ HMO – UHC ☐ HMO – Kaiser ☐ HDHP - UHC		$
Group Dental Insurance (Must complete separate application form)	☐ Employee ☐ Employee + 1 ☐ Full Family		☐ Low Option ☐ High Option	$
Vision (Must complete separate application form)	☐ Employee Only ☐ Full Family			$
Dependent Care Reimbursement – Flexible Spending Account				$
Medical Expense Reimbursement – Flexible Spending Account				$
Cancer Insurance - *Available only during annual Open Enrollment periods.*				$
Accident Insurance - *Available only during annual Open Enrollment periods.*				$

I ELECT TO RECEIVE THE FOLLOWING ADDITIONAL COVERAGES ON AN "AFTER-TAX" BASIS:

Prior to the beginning of each plan year, I will have the opportunity to enroll, cancel or change the following coverages.

Coverage	Option	Amount
Short-term Disability Benefits begin the 1st day for accident & 8th day for sickness and continue up to 180 days	☐ Weekly Benefit - 50% of Earnings ☐ Weekly Benefit - 60% of Earnings	$
Long-term Disability Benefits begin the 181st day of disability and continue up to normal retirement age	☐ Monthly Benefit - 50% of Earnings ☐ Monthly Benefit - 60% of Earnings	$
Basic Group Life - Equal to one times annual salary to a maximum of $50,000		No Cost
Supplemental Group Life $10,000 to $300,000 in $10,000 increments	Amount Selected: $ __________	$
Spouse Group Life $10,000 to $150,000 in $10,000 increments	Amount Selected: $ __________	$
Dependent Group Life Dependent children 6 months to 19 or 25 if full time student	☐ $5,000 ☐ $10,000	$
Sick Leave Bank I wish to donate one day of my accumulated sick leave to the Sick Leave Bank. *Available only during annual Open Enrollment periods.*	☐ Yes ☐ No	$
Individual Life Insurance - *Available only during annual Open Enrollment periods.*		$
Critical Illness - *Available only during annual Open Enrollment periods.*		$

I UNDERSTAND that if my required contributions for the selected benefits are increased or decreased while this agreement remains in effect, my compensation reduction will automatically be adjusted to reflect the change. Prior to the first day of each plan year, I will have the opportunity to change my benefit elections for the following plan year. If I do not complete and submit a new election form prior to a new plan year, I will be treated as having elected to continue my benefit elections then in effect for the new plan year. In addition, I understand changes in the elected deduction and benefits can only be made should in the event of a Section 125 qualifying event.

Date ____________________ **Signature** ____

Updated: 3/30/2022

Coweta County Schools
Dental & Vision
Enrollment/Change Form

DELTA DENTAL®

Employer Information				
Vision Group Number 9645805 **Dental Group Number** GA 16045	**Employer Name** Coweta County Schools	**Location Code**	**Division Code**	**Effective Date**

Employee Information		**A: Add**	**T: Terminate**	**C: Change**		
☐ A ☐ T ☐ C	**Sex** ☐ M ☐ F	**Member ID**	**Last Name**	**First Name**	**MI**	**DOB**
Social Security #		**Home Street Address**		**City, State/Zip**	**Home Phone**	

Family Information **V- Vision D- Dental**	**A: Add**	**T: Terminate**	**C: Change**			
☐Vision ☐Dental	☐ A ☐ T ☐ C	**Spouse Last**	**First Name**	**Gender**	**DOB**	**SSN**
☐Vision ☐Dental	☐ A ☐ T ☐ C	**Child Last Name**	**First Name**	**Gender**	**DOB**	**SSN**
☐Vision ☐Dental	☐ A ☐ T ☐ C	**Child Last Name**	**First Name**	**Gender**	**DOB**	**SSN**
☐Vision ☐Dental	☐ A ☐ T ☐ C	**Child Last Name**	**First Name**	**Gender**	**DOB**	**SSN**
☐Vision ☐Dental	☐ A ☐ T ☐ C	**Child Last Name**	**First Name**	**Gender**	**DOB**	**SSN**
☐Vision ☐Dental	☐ A ☐ T ☐ C	**Child Last Name**	**First Name**	**Gender**	**DOB**	**SSN**

I authorize EyeMed Vision Plan monthly payroll deduction for:

☐ I *decline* Vision Coverage

☐ Employee Only $6.09	☐ Family $14.48

I authorize Delta Dental Plan monthly payroll deduction for:

☐ I *decline* Dental Coverage

☐ Low Option	☐ Employee Only $16.44	☐ Employee + 1 $40.01	☐ Employee + Family $81.97
☐ High Option	☐ Employee Only $34.25	☐ Employee + 1 $84.00	☐ Employee + Family $129.73

Employee Signature: ______________________________ **Date:** ______________