Akron Public Schools

BENEFIT ELECTION FORM

Please indicate your selection by marking either A or B. If you select A, you must indicate the type of coverage and choice of provider. You will also be responsible for completing the applicable provider Enrollment Form. All completed forms must be submitted directly to the Akron Public Schools Benefits Office. PLEASE DO NOT SEND FORMS DIRECTLY TO THE INSURANCE PROVIDER.

SECTION A. – COVERAGE ELECTION

_____ Elections are made once per year. My election is for the plan year January 1, 2015 (or my effective date) through December 31, 2015. Unless I complete a new Election Form with changes, any elections or a default option that I have previously made will be in effect. Future elections/changes can be made during an authorized Open Enrollment Period, an authorized Special Enrollment Period or if I have a qualifying change in family status. I am electing coverage under the group medical/health plan for Akron Public Schools and agree to have salary reductions for the amount of the Employee Premium Contribution for my coverage as selected. The coverage I am entitled to under the medical plan will be determined in accordance with the terms and conditions of the medical plan, the selection form and the application form(s) I have filed under that plan.

MY ELECTION FOR HEALTH CARE PROVIDER DURING THE 2015 CALENDAR YEAR:

SINGLE COVERAGE: _____ FAMILY COVERAGE (spouse, dependents): _____

PROVIDER/PLAN _____ AultCare (PPO) _____ Medical Mutual of Ohio-*Super Med Plus* (PPO)

_____ Summa Care Health Plan (PPO) _____ Kaiser (HMO)

MY ELECTION FOR DENTAL COVERAGE** DURING THE 2015 CALENDAR YEAR:

_____ Delta Dental-Basic Plan (no premium) _____ Delta Dental Enhanced Plan (no premium IF in a PPO)

**Please Note: Child Nutrition Job Code 822 is NOT entitled to Dental or Vision Coverage

SECTION B. – WAIVER OF COVERAGE (Coverage OPT- OUT)

_____ I am eligible for group medical/health coverage (single or family) under the group medical/health plan for Akron Public Schools and choose to WAIVE coverage at this time. I acknowledge that I will receive reimbursement or payment in lieu of benefit coverage according to the provisions as outlined in the Collective Bargaining Agreement that applies to my job position. I understand that I am required to provide a copy of my current health care provider identification card and it must be attached to this form. I understand that this election has been made for the plan year beginning on January 1, 2015 and will be in effect until December 31, 2015 or until changed due to a qualifying change in family status or an authorized Open Enrollment Period.

Employee Name (please PRINT): _____

Employee Signature: _____ Date: _____

Employee ID# 0000_____ Assignment/Building: _____

WARNING: Any person who, with intent to defraud or knowingly is facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.