Independent School District No. 1 – Lewiston
2023-2024 6.00-6.75

PAYROLL DEDUCTION FORM

Please complete the information below. Use the Rate Chart on this form to calculate the monthly premiums for your benefits.

☐ **Certificated** ☐ **Non-Certificated**

Name: _____
Mailing Address: _____
Phone Number: _____
Date of Birth: _____
Social Security No: _____
☐ Male ☐ Female

Benefits Effective Date: _____
Status Change Date: _____
Full Time Hire Date: _____
Job Title: _____ Hours per Day _____
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Status Change Reason: ☐ Birth ☐ Marriage ☐ Divorce ☐ _____

Designate your election for Medical, Dental and Vision below. Complete the information for your dependents on the next page. Dependents will not be enrolled unless this information is complete.

MEDICAL	☐ **Basic PLAN 1: $1500 Deductible**		☐ **Optional PLAN 2: $3000 Deductible**	
	District	**Employee**	**District**	**Employee**
☐ Employee Only	$ 475.60	$ 104.40	$ 475.60	$ 52.85
☐ Employee + 1 Child	$ 662.40	$ 202.35	$ 662.40	$ 125.15
☐ Employee +2 Children	$ 748.40	$ 247.45	$ 748.40	$ 158.15
☐ Employee + Spouse	$ 894.10	$ 323.85	$ 894.10	$ 214.50
☐ Family	$ 1,017.42	$ 388.53	$ 1,017.42	$ 262.13
☐ **No Coverage (Waiving)**				

VISION	☐ **MONTHLY COST**	
	District	**Employee**
☐ Employee Only	$ 5.62	$ 1.23
☐ Employee + 1 Child	$ 9.95	$ 3.50
☐ Employee +2 Children	$ 9.95	$ 3.50
☐ Employee + Spouse	$ 9.80	$ 3.43
☐ Family	$ 13.29	$ 5.26
☐ **No Coverage (Waiving)**		

You have to have Medical in order to have Vision

DENTAL	☐ **DELTA DENTAL**		☐ **WILLAMETTE DENTAL**	
	District	**Employee**	**District**	**Employee**
☐ Employee Only	$ 1.70	$ 38.38	$ .93	$ 38.13
☐ Employee + 1 Child	$ 2.91	$ 65.69	$ 1.60	$ 65.29
☐ Employee +2 Children	$ 4.09	$ 92.75	$ 2.25	$ 92.18
☐ Employee + Spouse	$ 2.91	$ 65.69	$ 1.60	$ 65.29
☐ Family	$ 4.09	$ 92.75	$ 2.25	$ 92.18
☐ **No Coverage (Waiving)**				

MONTHLY EMPLOYEE COST FOR BENEFITS: $_____

_____

Employee Signature *Date*

By signing this form, you are giving your employer permission to enroll you and any dependents on the coverage(s) elected above. You are also giving permission to deduct your paycheck for the amounts you have indicated. If this form is not completed, your enrollment on the benefits may be delayed. By signing this application, I represent that all my answers are complete and accurate, and that I understand and agree to the following conditions:
I agree to abide by all of the terms and conditions of the Plan. Plan Administrator may terminate or rescind an employer' group coverage for any intentional misrepresentation omission of fact by, concerning, or on behalf of any applicant by the employer that was or would have been material to the acceptance of a risk, extension of coverage, provision of benefits or payment of any claim.

OFFICE USE ONLY: Date Completed: _____ Blue Cross of Idaho _____ Willamette _____ UH/VSP _____ Delta Dental

Dependent Enrollment Information

Eligible dependents are your legal spouse and dependent children under age 26.

PLEASE USE LEGAL NAME AS IT APPEARS ON THEIR SOCIAL SECURITY CARD

Dependent(s):					
Name: First, initial, Last	**Relationship** (Spouse, Child, Stepchild, etc.)	**Date of Birth**	**Gender**	**Social Security Number**	**Check benefits you are enrolling dependent on:**
			☐ Female ☐ Male		☐ Medical ☐ Dental ☐ Vision
			☐ Female ☐ Male		☐ Medical ☐ Dental ☐ Vision
			☐ Female ☐ Male		☐ Medical ☐ Dental ☐ Vision
			☐ Female ☐ Male		☐ Medical ☐ Dental ☐ Vision
			☐ Female ☐ Male		☐ Medical ☐ Dental ☐ Vision
			☐ Female ☐ Male		☐ Medical ☐ Dental ☐ Vision
			☐ Female ☐ Male		☐ Medical ☐ Dental ☐ Vision
			☐ Female ☐ Male		☐ Medical ☐ Dental ☐ Vision

*You must select the correct coverage according to your election on page 1. For example, if you selected Family Coverage for Medical, you must check the Medical box for your Spouse and at least 1 child.