

Health Insurance Consortium of *San Joaquin*
JEFFERSON ELEMENTARY SCHOOL DISTRICT- CERTIFICATED
CVT BRONZE PLAN SELECTION FORM - "NON-CAP" EMPLOYEES

Date of Enrollment/Change: _____	New Enrollment: <input type="checkbox"/>
Date of Hire: _____	Open Enrollment: <input type="checkbox"/>

Last Name:	First:	M:	<input type="checkbox"/> Single	<input type="checkbox"/> Married
			<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed
Street Address:		City:	State:	Zip:
Employee ID #:	Social Security Number:		Date of Birth:	

2017-18 PLAN YEAR - CERTIFICATED "NON-CAP" EMPLOYEE ONLY		
CVT ANTHEM BLUE CROSS MEDICAL PPO BRONZE PLAN	GROUP NUMBER	MONTHLY EMPLOYEE COST
70% PLAN - DEDUCTIBLE: \$5,000 INDIVIDUAL / \$10,000 FAMILY	1853YA	<input type="checkbox"/> \$823.00 EMPLOYEE & FAMILY COVERAGE

_____ I understand that I am solely responsible for the full premium cost of the medical plan selected above, as demonstrated by checking the box under Monthly Employee Cost.
 Initial

_____ I understand and agree that I must pay the full 1st month premium by check/money order by the 15th of the month prior to the start of coverage. For new hire employees, with an employment start date after the 15th of the month, the full 1st month premium is due on the on the 1st day of employment.
 Initial

_____ After payment of the 1st month premium, I agree to have the monthly premium for the coverage selected above deducted from my payroll earnings prior to any elective deductions, including direct deposit elections.
 Initial

_____ I further agree and understand that any payroll earnings will be available for the deduction of premium coverage selected above.
 Initial

_____ I understand enrolling in this medical plan means that I cannot be enrolled in a dental or vision plan.
 Initial

_____ I understand and agree that if I do not have sufficient earnings to cover the monthly premium amount due, I must pay the balance of premium due by no later than the 15th of the month of coverage
 Initial

_____ I understand that it is solely my responsibility to determine the premium balance due by the 15th of the month. Although, Jefferson may provide an invoice for the balance due, lack of receipt of such an invoice does not relieve my obligation to pay the full premium balance by the 15th of the month of coverage.
 Initial

_____ I agree and understand that if at any time, my checks provided for payment of any portion of medical premium are returned as unpaid from my bank for any reason (insufficient funds, closed account), this will be deemed as not having met the requirement to pay the full premium by the 15th of the month of coverage.
 Initial

_____ I understand and agree that failure to pay the full premium balance due by the 15th of the month of coverage will result in immediate termination of coverage for that coverage month and for the remainder of the plan year. If my coverage is terminated for lack of payment of the full premium, I understand that such termination of coverage is retroactive to the 1st day of the coverage month and that I will be solely responsible for any and all claim costs incurred.
 Initial

Employee Understanding

I understand that my signature on this CVT Bronze Plan selection form for "Non-CAP" employees means that I have read and understand all of the contents of this form.

 Employee Signature

 Date

 Employer Signature

 Date