Health Insurance Consortium *of San Joaquin*

JEFFERSON ELEMENTARY SCHOOL DISTRICT - CLASSIFIED

SISC ANCHOR BRONZE PLAN SELECTION FORM - "NON-CAP" EMPLOYEES

Date of Enrollment/Change: _____	**New Enrollment:** ❑
Date of Hire: _____	**Open Enrollment:** ❑

Last Name:	First:	M:	❑ Single ❑ Married ❑ Divorced ❑ Widowed
Street Address:	City:	State:	Zip:
Employee ID #:	Social Security Number:		Date of Birth:

2017-18 PLAN YEAR - **CLASSIFIED "NON-CAP" EMPLOYEE ONLY**

SISC ANTHEM BLUE CROSS MEDICAL PPO ANCHOR BRONZE PLAN	GROUP NUMBER	MONTHLY EMPLOYEE COST
70% PLAN - DEDUCTIBLE: $5,000 INDIVIDUAL / $10,000 FAMILY	70102B	☐ $584.00 EMPLOYEE ONLY COVERAGE ☐ $917.00 EMPLOYEE & CHILD(REN) COVERAGE

_____ Initial — 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.

Employee Understanding

I understand that my signature on this SISC Anchor 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

White - Jefferson Canary - Employee