Gateway Community Charters Benefit Enrollment Form

Print Name: ______________________________ **Social Security #:** ______________________

School & Position: ______________________________ **Effective Date of Coverage: November 1, 2010**

Please indicate benefit change(s) being made:____

____

Full-time Employer Contributions towards benefits:

________	$800.00	- Employee + Family	________	$625.00	- Employee + Spouse
________	$625.00	- Employee + Child(ren)	________	$450.00	- Employee Only

Health and Welfare Selections (circle choices):
(Please circle the company and level of coverage desired; then extend the dollar amount to the column on the right.)

HEALTH INSURANCE*	**WESTERN HEALTH 1933**	**KAISER 1932**	
Employee Only	399.62	396.89	
Employee + Spouse	794.04	789.80	
Employee + Child(ren)	715.17	710.43	
Employee + Family	1,188.46	1,178.75	$______________

*If medical coverage is waived, evidence of other medical coverage must be provided.

DENTAL INSURANCE	**MET LIFE 2964**	
Employee Only	42.21	
Employee + Spouse	88.82	
Employee + Children	102.25	
Employee + Family	148.85	$______________

VISION INSURANCE	**V.S.P. 1934**	
Employee Only	6.40	
Employee + Spouse	13.66	
Employee + 1	13.95	
Employee + Family	22.48	$______________

TOTAL BENEFITS SELECTED **(line 1) $**______________

Total # Covered: ________________ **MONTHLY EMPLOYER CONTRIBUTION** **(line 2) $**______________

If your total benefits selected are **more than** your monthly District contribution, subtract line 2 from line 1. **The amount on line 3 will be deducted from your paycheck.** **(line 3) $**______________

PLEASE NOTE: If you have a balance on **line 3** you may have it deducted before or after taxes. It will be pre-tax unless you designate after tax. Please consult your tax advisor. **PLEASE INITIAL YOUR CHOICE BELOW**:

SECTION 125/BENEFIT SHEET CHOICE: PRE-TAX ___________ AFTER-TAX ___________

☐ I hereby decline coverage in the GCC sponsored medical plans. **Proof of other group medical coverage is attached**
By declining to participate in the GCC sponsored medical plans, I will not hold the GCC responsible for any claims that would otherwise be covered by these plans. I understand that I cannot enroll in a new plan or change my current plan until the next Open Enrollment period, unless I experience a qualified family status change (such as the loss of other coverage, a divorce, marriage, birth or adoption of a child). A qualified family status change must be completed within 30 days of the event. Contact the GCC Human Resources Department for forms and information.

I authorize Gateway Community Charters, Inc. to deduct line (3) balance, if any, from my salary warrant. This balance will be multiplied by 12 months and prorated according to my pay status (11 or 12 payments). This authorization shall remain in effect until I notify the district of a change in writing. The Gateway Community Charters, Inc has my authorization to CHANGE THE DOLLAR AMOUNT OF MY BENEFIT CONTRIBUTIONS, reflecting any changes in the cost of the medical, dental and life insurance that I currently have through the GCC.

Date________________ Signature____

For Benefits/Payroll Only:
For **11 month pay schedules,** additional summer health deferred payments **(line 4) $**______________
(**line 2** minus **line 1** times the number of summer deferred checks, divided by **11)**
If there is an amount on **line 3** (calculated by Benefits/Payroll technician)

Revised 8.27.10