Akron Public Schools

# BENEFIT ELECTION FORM

Elections are made once per year. My election for the 2020 plan year January 1, 2020 (or my effective date) through December 31, 2020. 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.

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|---|---|
| Medical Mutual of Ohio-*Super Med Plus* (PPO) Express Scripts (RX) | Circle one: SINGLE / FAMILY / OPT OUT (read below) |
| Delta Dental | Circle one: SINGLE / FAMILY / OPT OUT (read below) |
| Vision (VSP) | Circle one: SINGLE / FAMILY / OPT OUT (read below) |

**OPT OUT**: Please initial_____ I understand that I am eligible to participate in group health insurance coverage offered through Akron Public Schools. This plan meets requirements of Affordability and Minimum Value. In waiving coverage I understand that I and/or my dependents may enroll under this plan in the future only as the result of certain qualifying conditions.

Examples: Within 30 days of involuntarily loss of group coverage or during an approved open enrollment period.

Reason for waiving coverage: Please check one.

( ) Coverage through spouse's employer. ( ) Covered through a parent's employer.

( ) Under 65 retiree coverage by previous employer. ( ) Other, please specify_____

** Please Note: Child Nutrition Job Code 822 is NOT eligible for Dental or Vision Coverage*

*The undersigned certifies, to the best of my knowledge and belief, under penalty of perjury, the information listed above is true and complete.*

Employee ID#0000 _____ Employee Name (please PRINT): _____

Employee Signature: _____ Date: _____

Assignment/Building: _____Position: _____

**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.