Greater Johnstown School District

Insurance Questionnaire-Active Employees

Name: _____ Date of Hire: _____
(Please print)

Job Title: _____ Building: _____

As an employee of the Greater Johnstown School District (District), there are several options available to you. In order to be sure each employee has a proper understanding of these options, please carefully read and complete this form. **Write your initials** on the lines that correspond to the appropriate responses in the applicable areas.

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HEALTH INSURANCE:

As a District employee, you **MAY** be entitled to health insurance if the applicable individual contract or collective bargaining agreement provides for same and in accordance with those provisions. If you are provided health insurance coverage via a spouse or some other health insurance plan, you are not entitled to maintain dual health insurance coverage. Health insurance cannot begin until the first day of your employment with the District or during an open enrollment time period or if there is a qualifying event.

_____ I would like to receive District provided health insurance. I hereby attest that I am not covered under another health insurance plan.

(circle plan choice):

CDPHP MVP EMPIRE –PPO- B Low EMPIRE PPO-B High EMPIRE EPO Empire EPO w/HSA

Individual 2 Person Family

_____ **I would like to receive the insurance buyout (request a form to enroll).**

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NOTE: Information and enrollment forms regarding each of the above health insurance plans are available by contacting Human Resources at 762-4611, ext. 3163 in the Business Office. You are required to complete and submit the appropriate enrollment forms to Human Resources within the first 30 days of your starting date of employment or during the open enrollment periods of if there is a qualifying event, in order to enroll in District provided health insurance. If you choose to be covered by District provided health insurance, then you are required to contribute to health insurance premiums in accordance with the applicable individual contract or collective bargaining agreement provision, under the Section 125 plan and you are therefore required to complete a payroll deduction form.

DENTAL INSURANCE:

As a District employee, you **MAY** be entitled to dental insurance if the applicable individual contract or collective bargaining agreement provides for the same and in accordance with those provisions. Dental insurance cannot begin until the first day of your employment with the District. Please see your contract to find out which one you are eligible for.

_____ I would like to receive District provided dental insurance.

_____ I would not like to receive District provided dental insurance.

(circle plan choice):

Delta Dental Options:

HIGH- Individual Employee/Spouse Employee/Child Family

LOW- Individual Employee/Spouse Employee/Child Family

CSEA Dental Options:

Individual 2 Person Family

**Delta Dental plans have changed for the 23/24 school year. Please review new plan options on our district website.*

Greater Johnstown School District

Dependent Information/Questionnaire

Dependent's Name: ______________________________

DOB: ____________________

SSN: ____________________

Tobacco User: YES/ NO

Full-Time College Student: YES/ NO

Dependent's Name: ______________________________

DOB: ____________________

SSN: ____________________

Tobacco User: YES/ NO

Full-Time College Student: YES/ NO

Dependent's Name: ______________________________

DOB: ____________________

SSN: ____________________

Tobacco User: YES/ NO

Full-Time College Student: YES/ NO

Dependent's Name: ______________________________

DOB: ____________________

SSN: ____________________

Tobacco User: YES/ NO

Full-Time College Student: YES/ NO

Dependent's Name: ______________________________

DOB: ____________________

SSN: ____________________

Tobacco User: YES/ NO

Full-Time College Student: YES/ NO

GROUP LIFE INSURANCE:

As a District employee, you ***MAY*** be entitled to Group Life insurance if the applicable individual contract or collective bargaining agreement provides for the same and in accordance with those provisions. If you choose to be covered by District provided Group Life insurance, you are required to contribute to Group Life insurance premiums in accordance with the applicable individual contract or collective bargaining agreement provision. These premiums are deducted from employee paychecks and you are therefore required to complete a payroll deduction form.

_____ I would like to receive District provided Group Life insurance.

_____ I would not like to receive District provided Group Life insurance.

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NOTE: Information regarding each of the above health, dental and group life insurance plans (including appropriate enrollment forms) is available by contacting Human Resources at 762-4611, ext. 3163, in the Business Office. You are required to complete and submit the appropriate enrollment form to Human Resources in the Business Office in order to enroll in District provided health, dental or Group Life insurance. You cannot be covered by health, dental or group life insurance unless and until you complete and submit the appropriate enrollment form(s) within the first 30 days of your starting date of employment or during the open enrollment periods or if there is a qualifying event. If you choose to be covered by District provided health, dental or group life insurance, you are required to contribute to health, dental or group life insurance premiums in accordance with the applicable individual contract or collective bargaining agreement provision. These premiums are deducted from employee paycheck and you are therefore required to complete a payroll deduction form.

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This new hire insurance questionnaire must be completed and signed by each new hire and returned to Human Resources in the Business Office no later than 30 days from your start date.

I hereby acknowledge that I have read, understood and signed my entitlement to the benefits set forth in this document. I further acknowledge that if I have any questions or concerns regarding anything set forth herein, I have had an opportunity to ask those questions and discuss those concerns with Business Office representatives.

Employee's Signature: _____ Date: _____

Please provide the following information for our records only:

Date of Birth: _____ Home Telephone #: _____

Greater Johnstown School District

Medical Reimbursement & Dependent Care Section 125 Plan for Calendar Year 23-24

If you wish to participate in the medical reimbursement and/or dependent care portion of the Section 125 plan for the 23-24 calendar year, please complete the following and return to Human Resources within 30 days of your hire date. Please note that there is a new ruling which allows the Section 125 medical reimbursement to reimburse many non-prescription drugs and over-the-counter medications. If you would like more information on this, please contact Human Resources in the Business Office.

I elect to receive the following coverage(s) under the Section 125 Plan: (please check appropriate box(es). If you check medical reimbursement and/or dependent care, you must put in an amount (must be an annual amount).

☐Dependent Care $_____ ☐ Medical Reimbursement $_____

As an eligible employee in the above plan, I acknowledge that I have received the Summary Plan Description. I have read the Summary Plan Description and understand the benefits available to me as well as other rights and obligations that I have under the Plan. In accordance with my rights under the Plan, I elect the above benefits and designate the above amounts for each benefit I have selected for the plan year specified above. The Employer and I agree that my cash compensation will be reduced by the amounts above for each pay period and plan year (or during such portion of the year as remains after the date of this agreement).

I understand that:

1. I cannot change or revoke any of my elections or this compensation reduction agreement at any time during the plan year unless I have a change in family status (including marriage, divorce, death of a spouse or child, birth or adoption of a child, termination or commencement of employment of a spouse, change in my or my spouse's employment status from full-time to part-time or from part-time to full-time, my spouse or I taking an unpaid leave of absence, a substantial change in my family's health coverage due to a change in my spouse's employer sponsored health coverage or such other events as the Plan Administrator determines will permit a change or revocation of an election).

2. The Plan Administrator may reduce or cancel my compensation reduction or otherwise modify this agreement in the event they believe are advisable in order to satisfy certain provisions of the Internal Revenue Code.

3. Any amounts that are not used during a plan year to provide benefits will be forfeited and may not be paid to me in cash or used to provide benefits specifically for me in a later plan year.

This agreement is subject to the terms of the employer's section 125 plan as amended from time to time in effect shall be governed by and construed in accordance with applicable laws shall take effect as a sealed instrument under applicable laws and revokes any prior election and compensation reduction agreement relating to such plan.

Print Name: _____ Signature: _____

Address: _____

Social Security Number: _____ - _____ - _____ Date: _____

Home Building: _____ Telephone #: _____

Greater Johnstown School District

Insurance Premiums – Section 125 Plan for Calendar Year 23-24

Please note that effective January 1, 2020, all employees that have health, dental and/or life insurance with the Greater Johnstown School District from January 1, 2020 through December 31, 2020, will have their premium deducted under the Section 125 Plan. Please fill out one of the options below and return to Human Resources in the Business Office ASAP. If we do not receive this form within 30 days of your date of hire, then option 1 will be chosen for all of your premiums.

Option 1: I elect **to participate** in the premium conversion plan sponsored by the Greater Johnstown School District. I understand that by participating in the plan, my contributions towards my insurance plan(s) will be made on a pre-tax basis. I understand that I cannot change or revoke this agreement to any date prior to the next plan year. Prior to the next plan year, I will be offered the opportunity to change my benefit election for the following year. I have checked below the plan(s) I wish to have pre-taxed:

_____ Health _____ Dental

_____ _____

Employee Name Printed Employee's Signature

_____ _____

Dated Home Building

Option 2: I elect **to waive participation** in the premium conversion plan sponsored by the Greater Johnstown School District. I understand that by waiving participation in the plan, my contributions towards my insurance plan(s) will be made on a post-tax basis. I understand that I cannot change or revoke this agreement at any date prior to the next plan year. Prior to the next plan year, I will be offered the opportunity to change my benefit election for the following year. I have checked below the plan(s) I wish to pay for on an after tax basis.

_____ Health _____ Dental

_____ _____

Employee Name Printed Employee's Signature

_____ _____

Dated Home Building