

Dover Area School District **Plan Year: July 1, 2024 through June 30, 2025**
Confidential Staff 12-month Employees = 26 pays (26 deductions from July 1, 2024 through June 30, 2025)

Name: _____

Current Coverage: _____ Current Dependents: _____

Medical
 Dental
 Vision

LBT Form must also be completed if there is a change in your Dependents.

2024 - 2025 Open Enrollment Elections

Medical (No Spousal Surcharge)*		Medical (with \$225 Spousal Surcharge)**
	Bi-weekly costs	Bi-weekly costs
T1 - Employee	\$ 41.54 <input type="checkbox"/>	
T2 - 2 Party (Emp/Child)	\$ 74.77 <input type="checkbox"/>	
T3 - 2 Party (Emp/Spouse)*	\$ 93.46 <input type="checkbox"/>	2 Party (Emp/Spouse)** \$197.31 <input type="checkbox"/>
T4 - Family (Emp/Children)	\$ 87.23 <input type="checkbox"/>	
T5 - Family (Emp/Spouse/Children)*	\$120.46 <input type="checkbox"/>	Family (Emp/Spouse/Children)** \$224.31 <input type="checkbox"/>

I elect to Waive Medical Insurance for 2024-25 Plan year.

** Per the DAESPA Contract, Employees whose spouse is employed and is eligible for medical and health insurance through their employer and decides to not enroll in their employer's insurance but is enrolled in the school districts medical and health insurance shall be charged a \$225 per month surcharge. All employees who are covering a spouse must complete the Spousal Eligibility Certification and Verification form(s) annually during Opening Enrollment.*

Dental		Vision	
Employee	\$0.81 <input type="checkbox"/>	Employee	\$ 3.44 <input type="checkbox"/>
2 Party	\$1.76 <input type="checkbox"/>	2 Party	\$ 6.48 <input type="checkbox"/>
Family	\$2.33 <input type="checkbox"/>	Family	\$10.08 <input type="checkbox"/>
<input type="checkbox"/> I elect to Waive Dental Insurance.		<input type="checkbox"/> I elect to Waive Vision Insurance.	

Medical Plan Election Cost: \$ _____

Dental Plan Election Cost: \$ _____

Vision Plan Election Cost: \$ _____

Total Payroll Contributions: \$ _____ *All my payroll contributions are Pre-tax, with tax savings.*

Signature Requirement:

In signing this Form, I am stating that I understand all the provisions, including the benefit, tax and cost associated with the choices I have made, as described either on this Form, the benefits plan brochures, or in the IRC Section 125 Summary Plan Description (SPD). I recognize that any amount cited on the "Total Payroll Contributions" Line of this form should represent my payroll contribution to the cost of my elected benefits. Furthermore, in the event that I have waived coverage in these plans, for myself or for my dependents, I recognize that for such associated benefit(s) I will not receive nor expect to receive coverage until such time that I may make a qualified re-enrollment in that/those plan (s) offered by the Dover Area School District under this IRC Section 125 Plan arrangement. I attest to the fact that my elections made on the form were done so of my own volition and that they are true and accurate to the best of my ability. Lastly, I recognize that I may not change my election, unless one of the following shall occur in my circumstances: New Marriage or Divorce, Death of Family Member, New Birth/Adoption of Child, or change in Employment Status for myself or my Spouse. Having read this and the details described in the Summary Plan Description (available on the DASD website), I attest that my elections made on the Form represent my consent toward any applicable payroll contribution, waiver and payroll tax treatment decision.

Signature: _____

Date: _____

HR USE ONLY: _____ Update Database _____ Update Highmark _____ Update Delta _____ Update Davis
 _____ NO CHANGES _____ Update Skyward Deductions _____ Update Skyward Benefits _____ Update Excel