Dover Area School District **Plan Year: July 1, 2024 through June 30, 2025**

Support Staff 10-month Employees = 20 pays (20 deductions from September 6, 2024 through May 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 - Support Staff

Medical (No Spousal Surcharge)*	Bi-weekly costs		Medical (with $225 Spousal Surcharge)**	Bi-weekly costs	
T1 - Employee	$ 54.00	☐			
T2 - 2 Party (Emp/Child)	$ 97.20	☐			
T3 - 2 Party (Emp/Spouse)*	$121.50	☐	2 Party (Emp/Spouse)**	$256.50	☐
T4 - Family (Emp/Children)	$113.40	☐			
T5 - Family (Emp/Spouse/Children)*	$156.60	☐	Family (Emp/Spouse/Children)**	$291.60	☐

☐ 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 district's 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	$1.05	☐	Employee	$ 4.48	☐
2 Party	$2.29	☐	2 Party	$ 8.42	☐
Family	$3.02	☐	Family	$13.10	☐
☐ I elect to Waive Dental Insurance.			☐ 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 Spreadsheet* _____ *Update Highmark* _____ *Update Delta* _____ *Update Davis*

_____ *NO CHANGES* _____ *Update Skyward Deductions* _____ *Update Skyward Benefits* _____ *Update Excel*