PETALUMA CITY SCHOOLS (Classified Staff)
HEALTH BENEFITS ELECTION FORM FOR OCTOBER 1, 2026 TO SEPTEMBER 30, 2027

SECTION 1: EMPLOYEE INFORMATION		
Employee:		Employee ID:
Date:	Position / Site:	Hours / Day:

SECTION 2: ELIGIBILITY INFORMATION FOR BENEFITS EFFECTIVE: _____

☐ I have been advised of my eligibility for coverage under the District's group insurance plan as follows:

☐ I understand the District will pay up to:
_____% of the medical Cap ($1,190.13) for a **health plan** premium.
_____% of the **dental** Cap ($144.50) and/or **vision** plan ($29.00).
I will be responsible for the remainder of the premium and authorize the deduction(s) from my paychecks.

☐ I have been advised that any insurance I elect will remain in effect through September 30, 2027, unless I have a qualifying event.

☐ I have received the IRS Section 125 Benefit Overview.

☐ I have notified the district that I have a spouse who is also employed through the district. Spouse Name: _____
May be eligible for discounted premium rate if dual enrollment

SECTION 3: BENEFIT ELECTION(S) AND / OR WAIVER(S)

I ELECT COVERAGE UNDER THE FOLLOWING PLAN(S) (SEE REVERSE SIDE FOR DETAILED RATE INFORMATION):

☐ **Blue Shield 90% PPO** ($20 OV / 10% Hospital Admit)	☐ **Kaiser High** ($20 OV / $0 Hospital Admit)
☐ **Blue Shield 80% PPO** ($30 OV / 20% Hospital Admit)	☐ **Kaiser Mid** ($500 Individual / $1,000 Family Deductible)
☐ **Blue Shield HD PPO** ($3,400 Individual / $6,800 Family Deductible)	☐ **Kaiser Low** ($1,700 Individual / $3,400 Family Deductible)
☐ **Blue Shield Anchor Bronze** (Minimum Value Plan)	☐ **Delta Dental** ($1,900 Calendar Year Maximum per Enrollee)
☐ **Vision Service Plan** ($15 OV / $120 Frame Allowance)	☐ **Madison National Life Insurance** ($37,000 Policy)

☐ **WABE** (Waiver of Active Benefit Election) – for full-time employees **ONLY**

I WAIVE MY RIGHTS TO BENEFITS FOR THE FOLLOWING COVERAGE(S):

☐ Medical	☐ Dental	☐ Vision	☐ Life

My waiver of any benefits is made with the understanding that I will not be eligible for insurance coverage until the next open enrollment period and that such benefits would not be available until October 1, 2027, unless my coverage through another employer or government sponsored health care plan terminates as a result of any of the following qualifying events:

• Termination of employment	• Cessation of the other employer's contribution toward coverage
• Change in employment status	• Divorce from the person through whom I am covered as a dependent
• Termination of the other plan's coverage	• Termination of domestic partnership from the person through whom I am covered as a dependent
	• The death of the person through whom I am covered as a dependent

SECTION 4: DISCLOSURES

☐ I understand that the rate information on the next page is based on the monthly premium for each plan. Kaiser High, Kaiser Mid, Kaiser Low, Blue Shield 90%, Blue Shield 80% and Blue Shield HD have composite rates. Blue Shield Anchor Bronze (Minimum Value Plan) has tiered rates. I understand that my premium may vary depending on the plan I select and the number of dependent(s) enrolled on my plan.

☐ I understand that COBRA rates vary by plan and are subject to a 2% surcharge. KH-2, KM, KL, BS 90%, BS 80% and BS HD COBRA rates are based on the composite rate charged to active employees. Blue Shield Anchor Bronze (Minimum Value Plan) rates are based on the tiered rate charged to active employees.

☐ I have been advised any child(ren) may be enrolled on my insurance plan(s) until the first of the month after their 26th birthday and that I will receive COBRA continuation of coverage information from the District's COBRA Administrator, RESIG, upon termination of his / her coverage on my plan(s).

☐ I understand that the fair market value of the health insurance coverage provided by Petaluma City Schools to cover my domestic partner and his / her child(ren) may be reported as taxable income on my W-2.

☐ I agree to notify Human Resources within 30 days of any change in my dependent(s) status due to marriage / domestic partnership, divorce / end of domestic partnership, birth / adoption, or death.

☐ I will be responsible for any claims incurred by ineligible dependents as a result of providing false information or not reporting changes within the 30 day time limit.

SECTION 5: AUTHORIZATION

All information of this form is true and correct. I understand that it is the basis on which coverage may be issued under the plan or provided by the District. I understand that I must notify Human Resources immediately of any qualifying events. Any misstatements or omissions may result in future claims being denied and / or the policy being rescinded. Additionally, any person who knowingly and with intent to injure, defraud, or deceive the District or insurance carrier or plan service provider, by filing a statement or claim containing false or misleading information may be guilty of a criminal act punishable under law. The District will report all cases of fraud to the proper authorities. I attest by signing below that I have reviewed the information provided on this page and, to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements.

Employee Signature:	**Date:**

HR Initials: _____ 06.30.26

PETALUMA CITY SCHOOLS (CSEA Staff)
OCTOBER 1, 2026 TO SEPTEMBER 30, 2027

PLAN OPTIONS AND PREMIUMS - DISTRICT PAID CAP FOR FULL-TIME EMPLOYEES → $1,190.13 PER MONTH	
"Per paycheck" calculation is for informational purposes only and does not account for late starts, October 1st rate changes or plan changes during open enrollment. Actual "per paycheck" calculations are calculated manually by payroll and are based on the situation for the specific employee.	
Kaiser High - $2,680.00 monthly premium / $1,190.13 District-paid Cap for full-time employees & qualifying family members	
100%	$1,489.87 per month over District-paid Cap (11 paychecks per year - $1,625.31 per paycheck)
75%	$,1787.40 per month over District-paid Cap (11 paychecks per year - $1,949.89 per paycheck)
Kaiser Mid - $2,368.00 monthly premium / $1,190.13 District-paid Cap for full-time employees & qualifying family members	
100%	$1,777.87 per month over District-paid Cap (11 paychecks per year - $1,284.95 per paycheck)
75%	$1,475.40 per month over District-paid Cap (11 paychecks per year - $1,609.53 per paycheck)
Kaiser Low - $1,735.00 monthly premium / $1,190.13 District-paid Cap for full-time employees & qualifying family members	
100%	$544.87 per month over District-paid Cap (11 paychecks per year - $594.40 per paycheck)
75%	$842.40 per month over District-paid Cap (11 paychecks per year - $918.98 per paycheck)
Blue Shield 90% PPO - $2,413.00 monthly premium / $1,190.13 District-paid Cap for full-time employees & qualifying family members	
100%	$1,222.87 per month over District-paid Cap (11 paychecks per year - $1,334.04 per paycheck)
75%	$1,520.40 per month over District-paid Cap (11 paychecks per year - $1,658.62 per paycheck)
Blue Shield 80% PPO - $2,119.00 monthly premium / $1,190.13 District-paid Cap for full-time employees & qualifying family members	
100%	$928.87 per month over District-paid Cap (11 paychecks per year - $1,013.31 per paycheck)
75%	$1,226.40 per month over District-paid Cap (11 paychecks per year - $1,337.87 per paycheck)
Blue Shield HD PPO - $1,600.00 monthly premium / $1,190.13 District-paid Cap for full-time employees & qualifying family members	
100%	$409.87 per month over District-paid Cap (11 paychecks per year - $447.13 per paycheck)
75%	$707.40 per month over District-paid Cap (11 paychecks per year - $771.71 per paycheck)
Waiver of Active Benefit Enrollment (WABE) – $892.00 monthly premium / $1,190.13 District-paid Cap for full-time employees	
100%	$0 per month over District-paid Cap
Blue Shield Anchor Bronze (Minimum Value Plan) – Employee: $892.00 / Employee + Child(ren) $1,421.00 *(Not Eligible: Spouses / Domestic Partners)*	
Employee Only	
100%, 75%	$0 per month over District-paid Cap
Employee + Child(ren) *(Spouses / Domestic Partners - Not Eligible)*	
100%	$230.87 per month over District-paid Cap (11 paychecks per year - $251.86 per paycheck)
75%	$528.40 per month over District-paid Cap (11 paychecks per year - $576.44 per paycheck)
Delta Dental - $111.00 monthly premium / $144.50 District-paid Cap for full-time employee	
100%	$0 per month
75%	$2.62 per month (11 paychecks per year - $2.86 per paycheck)
50%	$38.75 per month (11 paychecks per year - $42.27 per paycheck)
25%	$74.87 per month (11 paychecks per year - $81.68 per paycheck)
Vision Service Plan - $29.00 monthly premium **May be joined with Blue Shield and Kaiser Low plans. (Kaiser High and Mid include Kaiser vision)*	
100%	$0 per month
75%	$7.25 per month (11 paychecks per year - $7.91 per paycheck)
50%	$14.50 per month (11 paychecks per year - $15.82 per paycheck)
25%	$21.75 per month (11 paychecks per year - $23.73 per paycheck)
Madison National Life Insurance - $5.55 monthly premium	
When eligible, premium 100% paid by the district.	