

Health Insurance Consortium of *San Joaquin*  
**JEFFERSON ELEMENTARY SCHOOL DISTRICT- CERTIFICATED**  
**CVT BRONZE PLAN SELECTION FORM - "NON-CAP" EMPLOYEES**

Date of Enrollment/Change: _____	New Enrollment: <input type="checkbox"/>
Date of Hire: _____	Open Enrollment: <input type="checkbox"/>

Last Name:	First:	M:	<input type="checkbox"/> Single	<input type="checkbox"/> Married
			<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed
Street Address:		City:	State:	Zip:
Employee ID #:	Social Security Number:		Date of Birth:	

2017-18 PLAN YEAR - <b>CERTIFICATED "NON-CAP" EMPLOYEE ONLY</b>		
<b>CVT ANTHEM BLUE CROSS MEDICAL PPO BRONZE PLAN</b>	<b>GROUP NUMBER</b>	<b>MONTHLY EMPLOYEE COST</b>
70% PLAN - DEDUCTIBLE: \$5,000 INDIVIDUAL / \$10,000 FAMILY	1853YA	<input type="checkbox"/> \$823.00 EMPLOYEE & FAMILY COVERAGE

\_\_\_\_\_  
Initial      I understand that I am solely responsible for the full premium cost of the medical plan selected above, as demonstrated by checking the box under Monthly Employee Cost.

\_\_\_\_\_  
Initial      I understand and agree that I must pay the full 1<sup>st</sup> month premium by check/money order by the 15<sup>th</sup> of the month prior to the start of coverage. For new hire employees, with an employment start date after the 15<sup>th</sup> of the month, the full 1<sup>st</sup> month premium is due on the on the 1<sup>st</sup> day of employment.

\_\_\_\_\_  
Initial      After payment of the 1<sup>st</sup> month premium, I agree to have the monthly premium for the coverage selected above deducted from my payroll earnings prior to any elective deductions, including direct deposit elections.

\_\_\_\_\_  
Initial      I further agree and understand that any payroll earnings will be available for the deduction of premium coverage selected above.

\_\_\_\_\_  
Initial      I understand enrolling in this medical plan means that I cannot be enrolled in a dental or vision plan.

\_\_\_\_\_  
Initial      I understand and agree that if I do not have sufficient earnings to cover the monthly premium amount due, I must pay the balance of premium due by no later than the 15<sup>th</sup> of the month of coverage

\_\_\_\_\_  
Initial      I understand that it is solely my responsibility to determine the premium balance due by the 15<sup>th</sup> of the month. Although, Jefferson may provide an invoice for the balance due, lack of receipt of such an invoice does not relieve my obligation to pay the full premium balance by the 15<sup>th</sup> of the month of coverage.

\_\_\_\_\_  
Initial      I agree and understand that if at any time, my checks provided for payment of any portion of medical premium are returned as unpaid from my bank for any reason (insufficient funds, closed account), this will be deemed as not having met the requirement to pay the full premium by the 15<sup>th</sup> of the month of coverage.

\_\_\_\_\_  
Initial      I understand and agree that failure to pay the full premium balance due by the 15<sup>th</sup> of the month of coverage will result in immediate termination of coverage for that coverage month and for the remainder of the plan year. If my coverage is terminated for lack of payment of the full premium, I understand that such termination of coverage is retroactive to the 1<sup>st</sup> day of the coverage month and that I will be solely responsible for any and all claim costs incurred.

**Employee Understanding**

I understand that my signature on this CVT Bronze Plan selection form for "Non-CAP" employees means that I have read and understand all of the contents of this form.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employer Signature

\_\_\_\_\_  
Date