ACALANES UNION HIGH SCHOOL DISTRICT

Election Form - Dental & Vision Plans

1. PERSONAL INFORMATION:

NAME: _____ _____
First Last

Address: _____ _____
Street City

_____ _____ _____
State Zip ( ) Phone

_____ _____
Employee ID Birthdate

Dependents:
(Name\DOB) _____ _____
(spouse\domestic partner) (DOB)

_____ _____ _____ _____
(child) (DOB) (child) (DOB)

_____ _____ _____ _____
(child) (DOB) (child) (DOB)

_____ _____ _____ _____
(child) (DOB) (child) (DOB)

2. SELECT COVERAGE: (Based on 1.0 FTE)

[ ] DELTA DENTAL BASIC PLAN

[ ] DELTA PPO PLAN - Buy Up $37.60 per month**

[ ] CANCEL - DELTA PPO PLAN Buy Up

[ ] VSP BASIC PLAN

[ ] VSP PLAN - Buy Up $4.60 per month

[ ] CANCEL - VSP Buy Up

To locate Delta PPO Network Providers, visit deltadentalins.com and select: DELTA DENTAL PPO Network

By choosing the Delta PPO Plan I understand that I am responsible for a greater portion of my dental costs if I use an out of network provider. **I realize that I can not change this election until the next Open Enrollment. I also understand that by changing my current plan my benefits will restart at 70%.

3. SIGNATURE: _____ **DATE:** _____