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 YOUR DENTAL COVERAGE: (Based on 1.0 FTE)

[ ] DELTA DENTAL BASIC PLAN

[ ] DELTA PPO PLAN - Buy Up $34.60 per month(Based on 1.0 FTE)**

[ ] CANCEL - DELTA PPO PLAN Buy Up

All Employees are enrolled into Vision Service Plan-$0 office visit, $200 Frame

To locate Delta Dental Network Providers, visit https://www1.deltadentalins.com/individuals/find-a-dentist.html select: DELTA DENTAL PREMIER Network for the Basic Plan & DELTA DENTAL PPO Network for the Buy Up Plan

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:** _____