

ACALANES UNION HIGH SCHOOL DISTRICT

Election Form - Dental & Vision Plans

1. PERSONAL INFORMATION:				
NAME:	First		Lock	
	First		Last	
ADDRESS:	DRESS: Street		City	
	Sirect			
	State	Zip	() Phone	
	Employee ID	Birthdate		
2 SELECT	COVEDAGE			
2. SELECT COVERAGE:				
[] VSP PLAN - Buy Up \$4.60 per month				
[] CANCEL - VSP PLAN Buy Up				
	[] CANCEL - VSI I LAN Buy Op			
[] DELTA PPO PLAN - Buy Up \$31 per month				
[] CANCEL DELTA DDO DLAN DUVLID				
[] CANCEL - DELTA PPO PLAN Buy Up				
To locate Delta PPO Network Providers, visit <u>deltadentalins.com</u> 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%.				
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3. SIGNATURE:				

S:Business Services/Benefits/Open Enrollment 2018-2019/Active Employees