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

2. SELECT COVERAGE:

[ ] VSP PLAN - Buy Up $4.60 per month

[ ] CANCEL - VSP PLAN Buy Up

[ ] DELTA PPO PLAN - Buy Up $31 per month

[ ] CANCEL - DELTA PPO PLAN 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: _____