MEDICAL PLAN SELECTION REQUEST FORM

SRJC ADJUNCT FACULTY

_____ _____

Employee's Printed Name Employee I.D. Number

Please select which medical plan you'd like to enroll in below. Benefit Summaries of these five SRJC medical plans can be found at: https://hr.santarosa.edu/employee-benefits-information

Options 4 and 5 are high deductible plans. If you choose to enroll in one of these high deductible plans, the District will contribute into a Health Savings Account (HSA) on your behalf in the amounts listed below:

HSA Single: $50 per month ($600 per year)
HSA Double:$75 per month ($900 per year)
HSA Family: $75 per month ($900 per year)

1. I select the SISC **Kaiser Permanente HMO** SRJC Group Medical Plan. **Check the coverage requested:**

_____ Single:	100% premium = $678.00	Adjunct 50% faculty portion = $339.00
_____ Double:	100% premium = $1,432.00	Adjunct 50% faculty portion = $716.00
_____ Family:	100% premium = $1,990.00	Adjunct 50% faculty portion = $995.00

2. I select the SISC **Blue Shield HMO** SRJC Group Medical Plan. **Check the coverage requested:**

_____ Single:	100% premium = $744.00	Adjunct 50% faculty portion = $ 372.00
_____ Double:	100% premium = $1,575.00	Adjunct 50% faculty portion = $787.50
_____ Family:	100% premium = $2,192.00	Adjunct 50% faculty portion = $1,096.00

3. I select the SISC **Blue Shield PPO** SRJC Group Medical Plan. **Check the coverage requested:**

_____ Single:	100% premium = $843.00	Adjunct 50% faculty portion = $421.50
_____ Double:	100% premium = $1,793.00	Adjunct 50% faculty portion = $896.50
_____ Family:	100% premium = $2,499.00	Adjunct 50% faculty portion = $1,249.50

4. I select the **Kaiser HSA** SRJC Group Medical Plan. **Check the coverage requested:**

_____ Single:	100% premium = $535.00	Adjunct 50% faculty portion = $267.50
_____ Double:	100% premium = $1,127.00	Adjunct 50% faculty portion = $563.50
_____ Family:	100% premium = $1,565.00	Adjunct 50% faculty portion = $782.50

5. I select the **SISC Blue Shield HSA** SRJC Group Medical Plan. **Check the coverage requested:**

_____ Single:	100% premium = $595.00	Adjunct 50% faculty portion = $297.50
_____ Double:	100% premium = $1,299.00	Adjunct 50% faculty portion = $649.50
_____ Family:	100% premium = $1,826.00	Adjunct 50% faculty portion = $913.00

I agree to pay the adjunct faculty portion of the plan I selected above, which is 50% of the premium cost on a monthly basis, for the period of April 1, 2020 through September 30, 2020.

_____ _____

Signature **Date**

*** Signed under penalty of perjury under the laws of the State California.*

*All information will be used exclusively by SRJC to administer the program and will not be disclosed unless required by law.