## **MEDICAL PLAN SELECTION REQUEST FORM**

## SRJC ASSOCIATE FACULTY

Employee Name	Employee I.D. Number
Please select which medica	al plan you'd like to enroll in below. Benefit Summaries of these five SRJC medical plans can be found at
https://hr.santarosa.edu/a	associate-faculty-medical-insurance
	0.00
1. I select the SISC <b>Kaiser F</b>	Permanente HMO SRJC Group Medical Plan. Check the coverage requested:
Single	
Double	
Family	
SRJC pays the e	entire monthly premium for the Kaiser HMO plan.
2. I select the SISC <b>Kaiser I</b>	Deductible HSA SRJC Group Medical Plan. Check the coverage requested:
Single	
Double Family	
•	entire monthly premium for the Kaiser Deductible HSA plan.
	hield PPO Deductible HSA SRJC Group Medical Plan. Check the coverage requested:
Single Double	
Family	
·	entire monthly premium for the Blue Shield PPO Deductible HSA plan.
4. I select the <b>Blue Shield</b> I	HMO SRJC Group Medical Plan. Check the coverage requested:
Single:	Associate faculty portion = \$119.00/month
Double:	Associate faculty portion = \$293.00/month
Family:	Associate faculty portion = \$420.00/month
5. I select the <b>SISC Blue Sh</b>	nield PPO SRJC Group Medical Plan. Check the coverage requested:
Single:	Associate faculty portion = \$243.00/month
Double:	Associate faculty portion = \$567.00/month
Family:	Associate faculty portion = \$806.00/month
I agree to pay the associat through March 31, 2026.	te faculty portion, if any, of the plan I selected above, for the period of October 1, 2025
Signature	Date

<sup>\*\*</sup> Signed under penalty of perjury under the laws of the State California.

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