## MEDICAL PLAN SELECTION REQUEST FORM SRJC ASSOCIATE FACULTY

Employee 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/associate-faculty-medical-insurance

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

HSA Single: \$600.00 HSA Double:\$900.00 HSA Family: \$900.00

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

Single Double Family

SRJC pays the entire monthly premium for the Kaiser HMO plan.

2. I select the SISC Kaiser Deductible HSA SRJC Group Medical Plan. Check the coverage requested:

Single Double Family

SRJC pays the entire monthly premium for the Kaiser Deductible HSA plan.

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

Single Double Family

SRJC pays the entire monthly premium for the Blue Shield Deductible HSA plan.

## 4. I select the Blue Shield HMO SRJC Group Medical Plan. Check the coverage requested:

Single:	Associate faculty portion = \$121.00/month
Double:	Associate faculty portion = \$295.00/month
Family:	Associate faculty portion = \$421.00/month

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

Single:	Associate faculty portion = \$229.00/month
Double:	Associate faculty portion = \$533.00/month
Family:	Associate faculty portion = \$756.00/month

I agree to pay the associate faculty portion, if any, of the plan I selected above, for the period of April 1, 2024 through September 30, 2024.

## 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.