Shasta County Office of Education
Plan Year – October 1, 2021 through September 30, 2022

ACCEPTANCE/DECLINATION OF COVERAGE FOR TEMPORARY, SUBSTITUTE, SEASONAL AND PART TIME EMPLOYEES (LESS THAN .50 FTE)

All temporary, substitutes, seasonal and part time employees (less than .50 FTE) have the ability to purchase health insurance through our office for themselves and their eligible dependent children. Enclosed please find a plan description of the insurance available for purchase. The monthly cost is $469.00 for employee only and $844.00 for employee plus child(ren). Please indicate below whether you would like to accept or decline the plan being offered.

ACCEPTANCE OF BENEFITS

I elect to enroll in the Anthem Blue Cross 2-Tier Anchor Bronze Plan - PPO and agree to pay the monthly cost. I understand that once enrolled, I may terminate coverage by submitting a request, in writing, 30 days prior to the end effective date. I understand that I will be required to submit my payment by check or money order to the payroll department at the Shasta County Office of Education by the first of each month in order to remain covered. Acceptance of benefits will require you to complete the attached enrollment form, attach all verification documents as described along with payment for the first month of coverage.

Print Name _____ Social Security Number _____

Employee Signature _____ Date _____

DECLINATION OF BENEFITS

I understand that I am eligible to purchase health insurance through Shasta County Office of Education. I further understand that if I decline coverage for eligible dependent children and myself at this time due to a financial burden, that neither my eligible dependents nor I will be allowed to enroll until the next open enrollment period.

I understand that if I decline coverage because I have health coverage elsewhere and subsequently lose that coverage, I may enroll immediately provided SCOE is notified within 30 days of loss of coverage.

Effective April 1, 2009 loss of coverage under a Medicaid plan, Children's Health Insurance Program (CHIP) or participation in a premium assistance program under Medicaid or CHIP affords you special enrollment rights. You must notify KCSOS within 60 days of loss of coverage. Enrollment form, or change form, and evidence of loss of coverage letter are required.

I understand that if I decline enrollment and subsequently become a permanent full-time employee (greater than .50 FTE), that I will be given the option to select coverage at that time.

Reason for declining Benefits: _____
(i.e. cost of coverage, other health coverage)

Print Name _____ Social Security Number _____

Employee Signature _____ Date _____

Please read the above statements and sign only one election. If you do not fully understand your election options, please contact the Human Resources Department.