Employee Benefits Enrollment Form (19 Pay Periods 8/31/2025-5/31/2026)
2025-2026 Plan Year

Event/Employer Information

Employee #:	Date of Hire:	Effective Date:

Event:
☐ New Hire ☐ Family Status Change ☐ Beneficiary Change
☐ Termination ☐ Open Enrollment ☐ Address Change ☐ Name Change

Work Status:
☐ FMLA ☐ Leave of Absence
☐ Paid ☐ Unpaid

Employee Information

Social Security #:	Last Name:	First Name:	MI:	Sex: ☐M ☐F	Date of Birth:

Street Address: **Apt #:** **City:** **State:** **ZIP Code:**

Marital Status:
☐ Single ☐ Married
☐ Divorced
☐ Widowed

Home Phone: ( )	Cell Phone: ( )	Employee Type: ☐Salary ☐Hourly ☐Percentage	Email Address:

Job Title: **Worksite Location:** **Work Phone:**

Family with 2 SJCSD Employees Spouse Name: **Employee ID#:** **Worksite Location:**

Male Fw2 – Add Dependents
Female Fw2 – No Dependents

Basic Life Insurance

Name of Beneficiary: **Relationship:** **%:** **Life Amount:**

Name of Contingent **Relationship:** **%:**

Please place an "X" next to the desired elections for Medical, Dental, and Vision Coverage.

In addition, select Pre- or Post-Tax for all deductions: ☐ Pre-Tax* ☐ Post-Tax

Percentage Teachers Only Waive Coverage: ☐ Indemnity ☐ Medical ☐ Dental ☐ Vision

Medical ☐ Indemnity	*Plan 1 (5770) STANDARD*			*Plan 2 (3769) BUY UP*		
	19-Pay Periods	*EE Pro-Rate*	*ER Pro-Rate*	*19-Pay Periods*	*EE Pro-Rate*	*ER Pro-Rate*
Employee Only	☐ $ 68.16			☐ $ 83.45		
Family with 2	☐ $ 154.74 ($77.37 EA)			☐ $ 227.14 ($113.57 EA)		
Family w/2 Single	☐ $ 136.32 ($68.16 EA)			☐ $ 166.90 ($83.45 EA)		
Family	☐ $ 287.20			☐ $ 360.19		

Dental	*Dental Plan 1*			*Dental Plan 2*		
	19-Pay Periods	*EE Pro-Rate*	*ER Pro-Rate*	*19-Pay Periods*	*EE Pro-Rate*	*ER Pro-Rate*
Employee Only	☐ $ 0.00			☐ $ 6.15		
Family with 2	☐ $ 5.08 ($2.54 EA)			☐ $ 23.20 ($11.60 EA)		
Family w/2 Single	☐ $ 0.00			☐ $ 12.30 ($6.15 EA)		
Family	☐ $ 21.47			☐ $ 41.59		

Vision	Employee Only	Family with 2	Family w/2 Single	Family	*EE Pro-Rate*	*ER Pro-Rate*
	☐ $ 0.00	☐ $ 3.88 ($1.94 EA)	☐ $ 0.00	☐ $ 7.82		

For Administrative Use:

STD ☐Opt 1 ☐Opt 2 ☐Opt 3 **LTD** ☐Basic ☐Buy-Up **Med 125**_____ **Dep 125**_____	**Add'l Term Life:** **EE** _____ **SP** _____ **CH**_____	**Spouse:** Missing_____ ☐Affidavit $0.00 or $35.00 ☐Marriage License ☐Bill/Income Tax Form	**Children:** ☐Birth Certificates – Have all? Missing: _____ _____

Continued on Other Side

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Please provide the required information for each dependent you are enrolling, continuing, or terminating Medical/Dental/Vision coverage. If enrolling new dependents, attach dependent eligibility documents (see list below).					**Election (E, C, T)** E = Enroll C = Continue T = Term		
Name (Last, First, MI)	*Relation*	*Social Security #*	*Sex*	*Date of Birth*	*Medical*	*Dental*	*Vision*
	Spouse						
	Child						
	Child						
	Child						
	Child						

Qualifying Events & Benefit Election Changes
As stated in the St. Johns County School District Employee Medical, Dental, and Vision Plans, I can only Add, Change, or Delete my medical, dental, or vision coverage during open enrollment unless I experience a Family Status Change during the Plan year and meet and complete the following requirements:

1. Family Status change will be the loss of health coverage due to the death of a spouse, termination of spouse's employment, divorce, or disability of a spouse. Other qualifying events are marriage, birth, dependent satisfies or ceases to meet requirements for coverage, adoption, or placement for adoption, etc.
2. Qualifying events must be reported to the Human Resources Benefits Department within 30 days from the event date. Any changes submitted after the 30 days will not be approved for employee insurance coverage.

Dependent Eligibility Documents

- **For Spouse:** A Certified copy of your Marriage Certificate **AND one of the following:** A copy of the front page of your 2023 federal tax return confirming this dependent is your spouse OR a document **dated within the last 60 days,** such as a recurring monthly household bill. **The document must list your name, your spouse's name, date, and mailing address.**
- **For Children up to age 26:** A certified copy of the child's birth adoption certificate naming you or your spouse as the child's parent. If you are covering a stepchild and your spouse is not a covered dependent, you must also provide documentation of your current relationship with your spouse as requested above.
- **For Children with Disabilities age 26 or older:** A copy of the child's birth certificate (or hospital birth record) AND Evidence of Social Security Disability (SSD) showing parent/guardian and dependent names.

2025 & 2026 HEALTH RISK ASSESSMENT PROGRAM
For complete program details, go to the "Benefits Bulletin Board" located at your worksite, sjcsd.mbaileygroup.com, the New Hire Benefits-at-a-Glance Booklet, and the 2025 Open Enrollment Benefits-at-a-Glance booklet.

Employees hired **after June 1, 2025**, must follow the steps outlined below based on their birth year:

- **Born in an EVEN year**: No action is required in **2025**. Employees and their spouses must complete these steps between **January 1, 2026**, and **November 15, 2026**.
- **Born in an ODD year**: No action is required in **2025**. Employees and their spouses must complete these steps between **January 1, 2027**, and **November 15, 2027**.

Spousal Surcharge $35 for 19 Pay Periods ☐ YES ☐ NO

***Compensation Reduction Agreement**
With this authorization, on the appropriate benefit enrollment form(s), I have enrolled for coverage under the St. Johns County School Board Employee Benefit Plan. I do elect to have insurance premiums deducted from my compensation for the Employee Benefit Plan coverage under Section 125 Plans. I do understand that if my required contributions to pay premiums for the elected benefits are increased or decreased while this agreement remains in effect, my compensation reduction will automatically be adjusted to reflect that increase or decrease. Before each Plan Year, I will be offered the opportunity to change my benefit election for the following Plan Year. *Open Enrollment changes do not require a new completed enrollment form.* I understand it is my responsibility to review my paycheck stub for accuracy and to report any discrepancies to the Benefits Department as soon as possible.

X_____Date: _____
Signature or legal representative signature