

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 SJCSJ 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		☐ \$ 70.93			☐ \$ 96.51				
Family with 2		☐ \$ 161.70 (\$80.85 EA)			☐ \$ 242.48 (\$121.24 EA)				
Family w/2 Single		☐ \$ 141.87 (\$70.93 EA)			☐ \$ 193.02 (\$96.51 EA)				
Employee Family		☐ \$ 298.21			☐ \$ 398.12				
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		☐ \$ 0.00			☐ \$ 6.15				
Family with 2		☐ \$ 5.08 (\$2.54 EA)			☐ \$ 30.50 (\$15.25 EA)				
Family w/2 Single		☐ \$ 0.00			☐ \$ 12.30 (\$6.15 EA)				
Employee Family		☐ \$ 21.47			☐ \$ 48.88				
Vision		Employee	Family with 2	Family w/2 Single	EE 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

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

2025-2026 Plan Year

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 2024 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