Part Time/Temporary/Seasonal Employee
2024-2025 Offer of Health Insurance

As an hourly, temporary or seasonal employee of the Central Union High School District, you are being given the opportunity to purchase health insurance for you and your eligible children. A summary of the available insurance plan is included in this packet. If you should choose to enroll, contact Jesus Bedolla at (760) 336-4509 for enrollment forms and other information. If you choose to opt out complete the declination at the bottom of this page and submit it to the Human Resources office.

To request enrollment on this plan, you must submit the following items to the district's Human Resources office no later than August 23, 2024. No late enrollments will be accepted.

- A completed and signed SISC III enrollment form
- Proof of eligibility for dependent children (birth certificates/adoption paperwork)
- First month's premium payment in the form of a check or money order in the applicable amount noted below
  - 2024-2025 Monthly Rates – Two Tier Anchor Bronze Plan
    - Employee Only: **$612.00**
    - Employee and Children: **$1,034.00**

Subsequent monthly payments are due in full by the 25th of the month prior to the coverage month. If payment is not received by the 1st of the coverage month, your coverage will be terminated. If your employment status ends at any time during the plan year, your coverage will be terminated the first of the month following. No reinstatements will be allowed.

If you fail to provide the items required for enrollment by August 23, 2024, you and your dependent children will not be allowed to enroll until the next Open Enrollment Period. Members who enroll during the Open Enrollment Period will become effective October 1, 2024.

Part Time/Temporary/Seasonal Employee
2024-2025 Declination of Health Insurance

I have read and understand the above notification. I understand that by declining coverage, I will not be able to enroll in coverage until the district's next Open Enrollment period.

I am declining health insurance coverage for the 2024-2025 plan year.

Print Name:_____

Signature: _____Date:_____

Social Security Number: _____

You are required to enroll or decline coverage by August 23, 2024
For additional information contact Jesus Bedolla at (760) 336-4509 or jbedolla@mycuhsd.org