Tucson Country Day School

UNITED HEALTHCARE 2023-2024 Employee Election Worksheet

Employee Information					
Last Name	First Name		MI	Social Security Number	
Address		Apt #	City	State	Zip Code
Date of Birth / /	Gender ☐ M ☐ F	Date of Hire / /		Home Phone	

Employees are eligible to enroll the first day of the month following their full-time date of hire.	**Deductions are based on 24 pay periods annually.**

United Healthcare Medical Plans

Please check the box for the coverage that you are electing below.

Coverage	Plan CZFW	Plan CZF6	Plan CZF3	Plan CZJE (HMO plan)	Plan DDVM (HSA plan)*
Employee Only	☐ $101.73	☐ $104.70	☐ $112.94	☐ $61.84	☐ $55.90
Employee + Spouse	☐ $452.57	☐ $459.09	☐ $477.22	☐ $364.79	☐ $351.71
Employee + Child(ren)	☐ $364.86	☐ $370.50	☐ $386.15	☐ $289.05	☐ $277.76
Family	☐ $744.92	☐ $754.41	☐ $780.78	☐ $617.25	☐ $598.23
Waive	. ☐ I do not elect **MEDICAL** coverage. *See Employee Benefits Folder for additional HSA Plan information.				

United Healthcare Dental and Vision Plans

Please check the boxes for the coverage that you are electing below. Choose only one dental plan.

Coverage	PPO Dental	Managed Care Dental		Vision	
Employee Only	☐ $18.87	☐ $6.90		☐ $3.45	
Employee + Spouse	☐ $40.18	☐ $12.06		☐ $6.55	
Employee + Child(ren)	☐ $37.89	☐ $14.94		☐ $7.68	
Family	☐ $61.16	☐ $18.96		☐ $10.81	
Waive	☐ I do not elect **DENTAL** coverage.			☐ I do not elect **VISION** coverage.	

Authorization & Enrollment

I hereby enroll, add or change, as elected above, coverage of group insurance for which I am eligible. I authorize my employer to make the above deductions from my pay. I understand that the only time I can make changes to my enrollment is during open enrollment or if I have a qualifying event. If I wish to make a change in coverage, I must notify Tucson Country Day School within 30 days of the qualifying event.

Employee Signature **Date:**

Keep your beneficiary form up to date for your TCDS Paid life insurance!

HMO Plan CHLN Only	Primary Care Doctor's Name	ID Number
Employee		
Spouse		
Child(ren)		

Please complete dependent information on the next page if enrolling dependents.

Dependent Information

Spouse	Last Name	First Name	MI
Social Security Number ___ ___ ___ – ___ ___ – ___ ___ ___ ___	Date of Birth / /	Gender ☐ M ☐ F	

Child	Last Name	First Name	MI
Social Security Number ___ ___ ___ – ___ ___ – ___ ___ ___ ___	Date of Birth / /	Gender ☐ M ☐ F	

Child	Last Name	First Name	MI
Social Security Number ___ ___ ___ – ___ ___ – ___ ___ ___ ___	Date of Birth / /	Gender ☐ M ☐ F	

Child	Last Name	First Name	MI
Social Security Number ___ ___ ___ – ___ ___ – ___ ___ ___ ___	Date of Birth / /	Gender ☐ M ☐ F	

Child	Last Name	First Name	MI
Social Security Number ___ ___ ___ – ___ ___ – ___ ___ ___ ___	Date of Birth / /	Gender ☐ M ☐ F	

Child	Last Name	First Name	MI
Social Security Number ___ ___ ___ – ___ ___ – ___ ___ ___ ___	Date of Birth / /	Gender ☐ M ☐ F	

Child	Last Name	First Name	MI
Social Security Number ___ ___ ___ – ___ ___ – ___ ___ ___ ___	Date of Birth / /	Gender ☐ M ☐ F	