The Discovery School of Virginia

Employee Elections for Plan Year Beginning: 2011

EMPLOYEE INFORMATION

Name:	**Work Phone#:**
Occupation / Job Title	**Location:**
Home Address:	**Contact Phone#:**
City, State, & Zip:	**S.S.#:**
Email:	**Birth Date:**

GROUP INSURANCE PLANS

Election #1: Group Medical Insurance

Check Plan	Group Insurance Plan Description	Type or Amount of Coverage	Number of Deductions	Deduction Amount
	Anthem Healthkeepers - HMO 20 POS			
	Employee Only		**24**	$57.74
	Employee + 1 Child		**24**	$79.42
	Employee + Children		**24**	$117.33
	Employee + Spouse		**24**	$128.64
	Employee + Family		**24**	$177.87
	Anthem Healthkeepers - HMO 25 POS			
	Employee Only		**24**	$53.14
	Employee + 1 Child		**24**	$73.14
	Employee + Children		**24**	$107.99
	Employee + Spouse		**24**	$118.34
	Employee + Family		**24**	$163.70
	Anthem Healthkeepers - HMO 25/500			
	Employee Only		**24**	$49.11
	Employee + 1 Child		**24**	$67.63
	Employee + Children		**24**	$99.80
	Employee + Spouse		**24**	$109.31
	Employee + Family		**24**	$151.26

DEPENDENT INFORMATION

First Name	Last Name	SSN#	D.O.B.	Relationship

Election #2: Group Dental Insurance

Check Plan	Group Insurance Plan Description	Type or Amount of Coverage	Number of Deductions	Deduction Amount
	Premier Option #1			
	Employee Only		**24**	$3.96
	Employee + Child (ren)		**24**	$7.44
	Employee + Spouse		**24**	$8.19
	Employee + Family		**24**	$11.78
	Premier Option #2			
	Employee Only		**24**	$6.95
	Employee + Child (ren)		**24**	$13.25
	Employee + Spouse		**24**	$14.59
	Employee + Family		**24**	$21.09

DEPENDENT INFORMATION

First Name	Last Name	SSN#	D.O.B.	Relationship

Election #3: Flexible Spending Accounts

Check Plan	Group Insurance Plan Description	Type or Amount of Coverage	Number of Deductions	Deduction Amount
	Medical Reimbursement		**24**	
	Dependent Care Reimbursement		**24**	
	Private Premium Reimbursement		**24**	

DEPENDENT INFORMATION

First Name	Last Name	SSN#	D.O.B.	Relationship

Election #4: Group Life Insurance

Check Plan	Group Insurance Plan Description	Type or Amount of Coverage	Number of Deductions	Deduction Amount
	The Principal Insurance Company		**24**	$0.00

BENEFICIARY ELECTION - 2011

Beneficiary: _____ Relationship_____

Address_____ D.O.B._____

Contingent Beneficiary: _____ Relationship_____

Address_____ D.O.B._____

I understand that I do not choose a beneficiary, the group life insurance benefits may be paid to my estate. I may choose to change beneficiaries at any time.

*** **Signature:** **Date:**

Election #5: Voluntary Supplemental Insurance

Check Plan	Group Insurance Plan Description	Type or Amount of Coverage	Number of Deductions	Deduction Amount
	Allstate			
	Cancer Insurance			
		Employee Only	**24**	$9.98
		Employee + Family	**24**	$16.81
	Accident Insurance			
		Employee Only	**24**	$9.20
		Employee + Family	**24**	$14.25
	Short Term Disability	Employee Only	**24**	Rates
		Employee + Family	**24**	Vary
	Life Insurance	Employee Only	**24**	Rates
		Employee + Family	**24**	Vary

WAIVER OF ELECTION

I do not want to participate in this Plan at this time. I realize that I will not become eligible again until the beginning of the next Plan Year, or if earlier, a change of status occurs such as marriage, divorce, birth or termination.

*** **Signature:** **Date:**

PARTICIPANT SIGNATURE

I want to participate in this Plan. I hereby make the following election regarding the benefits available to me under the Cafeteria Plan. I am further making an election to have my taxable compensation reduced by an amount equal to the value of the benefits specified below, such amount to be deducted in approximately equal sums from my regular paycheck during the current Plan Year.

I understand that I can not change this election during the plan year unless a change of status occurs such as a marriage, divorce, birth or termination.

*** **Signature:** **Date:**