

# Perth Amboy Board of Education

ADMINISTRATION HEADQUARTERS BUILDING

178 Barracks Street

Perth Amboy, New Jersey 08861

Tel: (732) 376-6200 Fax: (732) 638-1004



**Derek J. Jess**

School Business Administrator/

Board Secretary

## **HEALTH BENEFITS COVERAGE: 2019-2020 SCHOOL YEAR** **ADMINISTRATORS AND SUPERVISORS**

Your health insurance coverage will begin on the first day of your contractual employment. Employees are eligible for Medical (*Aetna*), Prescription (*Benecard*), Dental (*Delta Dental*) and Vision (*VSP*) coverage.

Please complete, sign and return this form along with the attached enrollment form to the Business Office as soon as possible. **If we do not receive your form within thirty (30) days of your hire date, the insurance companies will not accept you into their program.**

<b>Annual Premium</b>	<b>POS II</b>	<b>POS</b>	<b>PPO</b>
Single Premium	\$11,725	\$12,295	\$13,570
Family Premium	\$35,700	\$37,430	\$41,255

To estimate your required contribution, (1) multiply the appropriate premium by twenty-five percent (25%); that is your yearly contribution. (2) Next, divide your yearly contribution by 24 to calculate your per paycheck cost.

$$\begin{array}{ccccccc} \$ & & \times & 25\% & = & \$ & \div & 24 & = & \$ \\ \text{Premium Cost} & & & \text{Req. Contribution} & & \text{Yearly Cost} & & \text{\# of checks} & & \text{Per Paycheck Cost} \end{array}$$

Please indicate the coverage you wish to receive:

### **Single Coverage**

\_\_\_\_\_ POS II Plan

\_\_\_\_\_ POS Plan

\_\_\_\_\_ PPO Plan

### **Family Coverage:**

\_\_\_\_\_ POS II Plan

\_\_\_\_\_ POS Plan

\_\_\_\_\_ PPO Plan

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Print Name