## 2015-2016 Benefits Selections  Employee Name: _____

Listed below are the benefits I have selected as a benefit eligible employee. (Out of pocket deductions only apply when your selections are above the district allotted amount). **Please circle your selections below:**

### Kaiser Permanente HMO Plan

Employee Only - Employee/Spouse - Employee/Child(ren)- Employee/Family

### Premera Blue Cross PPO Plans

### Plan 2

Employee Only - Employee/Spouse - Employee/Child(ren)- Employee/Family

### Plan 3

Employee Only - Employee/Spouse - Employee/Child(ren)- Employee/Family

### Plan 5

Employee Only - Employee/Spouse - Employee/Child(ren)- Employee/Family

### EasyChoice A

Employee Only - Employee/Spouse - Employee/Child(ren)- Employee/Family

### EasyChoice B

Employee Only - Employee/Spouse - Employee/Child(ren)- Employee/Family

### Basic

Employee Only - Employee/Spouse - Employee/Child(ren)- Employee/Family

### HDHP w/HSA

Employee Only - Employee/Spouse - Employee/Child(ren)- Employee/Family

### Kaiser Permanente Dental DHMO Plan U

Employee Only - Employee/Spouse - Employee/Child(ren)- Employee/Family

### Kaiser Permanente Dental PPO Plan FG (Use Outside Kaiser Network)

Employee Only - Employee/Spouse - Employee/Child(ren)- Employee/Family

### Standard Insurance-Balanced Care Vision Plan1 (VSP)

Employee Only - Employee/Spouse - Employee/Child(ren)- Employee/Family

## I wish to OPT OUT OF:  Please circle:  MEDICAL  DENTAL  VISION

## Signature: _____  Date: _____