Albany County School District #1 Option Sheet

Printed Name: _____

Blue Cross Blue Shield ID Number: ZRW_____

Date of Birth: _____

As of July 1, 2019 I wish to ***change*** my current ***health insurance plan*** to the following plan with a change in deductible (if you have questions as to which plan you are on please call the payroll office):

_____ $1000 single/$2000 family deductible - $35.00 office visit copay

(employee paid premiums, single **$63**/mo., empl+1 **$199.50**/mo., empl+2 or more **$262.50**/mo.)

_____ $1500 single/$3000 family deductible - $40.00 office visit copay

(employee paid premiums, single **$26.25**/mo., empl+1 **$136.50**/mo., empl+2 or more **$178.50**/mo.)

_____ High Deductible Health Plan (HDHP) $2500 stacked single contract, $5000 stacked, all other contracts

(qualifies the policy holder the ability to have their own Health Savings Account)

(employee paid premiums, single **$6**/mo., empl+1 **$68.25**/mo., empl+2 or more **$89.25**/mo.)

By signing this form, I understand this deductible option will go into effect July 1, 2019 ***and remain in effect until June 30, 2020***.

Signature

Must be returned to the Payroll Office no later than May 31st, 2019.