Northern California Conference
HUMAN RESOURCES
Connections With A Purpose

2027 HEALTH CARE RATE CONFIRMATION

REQUIRED WHEN ENROLLING DEPENDENTS

RETURN COMPLETED FORM TO benefits@nccsda.com BY OCTOBER 13, 2026

1. EMPLOYEE INFORMATION

Employee name: _____ Employee ID: _____

Work location: _____ Effective date: _____

2. PLAN AND COVERAGE ELECTION

SELECT ONE MEDICAL PLAN	SELECT ONE ENROLLMENT TIER
☐ Ascend to Wholeness Accelerate	☐ Employee Only
☐ Ascend to Wholeness Access	☐ Employee + Spouse
☐ Kaiser Traditional	☐ Employee + 1 Child
☐ Kaiser Access DHMO	☐ Employee + 2 or More Children
	☐ Employee + Family

WELLNESS PROGRAM REQUIREMENT: To enroll in Ascend to Wholeness Accelerate or Kaiser Traditional, employees must have completed the applicable Wellness Program requirements by 07-31-2026.

3. 2027 MONTHLY EMPLOYEE MEDICAL CONTRIBUTIONS

Tier (Enrollment)	Ascend Accelerate	Ascend Access	Kaiser Traditional	Kaiser Access DHMO
Employee Only	$125.00	$130.00	$130.00	$140.00
Employee + Spouse	$325.00	$340.00	$340.00	$360.00
Employee + 1 Child	$185.00	$195.00	$195.00	$205.00
Employee + 2 or More Children	$250.00	$260.00	$260.00	$270.00
Employee + Family	$400.00	$420.00	$420.00	$440.00

Rates shown are monthly employee contributions. The $200 spouse surcharge is added only when applicable.

4. SPOUSE SURCHARGE CERTIFICATION

Complete only if enrolling a spouse under Employee + Spouse or Employee + Family. Select one:

☐ My spouse is unemployed or is not eligible for employer-sponsored medical coverage through another employer. No surcharge applies.

☐ My spouse is eligible elsewhere but elects NCC coverage. I understand that a $200 monthly spouse surcharge applies.

5. MONTHLY CONTRIBUTION CONFIRMATION

Selected plan/tier monthly rate	100
Applicable spouse surcharge	200
TOTAL MONTHLY EMPLOYEE CONTRIBUTION	300.00

I certify that the information provided above is accurate. I understand that I must notify Benefits if my spouse's eligibility for other employer-sponsored medical coverage changes.

Employee signature (required): _____ Date: _____

Questions? Contact Benefits at benefits@nccsda.com