VERNON PUBLIC SCHOOLS

TEACHER

Selection of Benefits – Open Enrollment

(Effective 07/01/17)

I understand that these monies will be used to cover my contribution toward the benefits listed below. This agreement will remain in effect until my employment terminates, a qualifying event occurs (i.e. marriage, divorce, death of spouse or dependent, spouse loses or obtains a job, reduction in hours, unpaid leave of absence for you or your spouse, birth or adoption of a child, etc.) my benefits change at the beginning of a new plan year, or my employer modifies the plan. The 2017-2018 rates and provider listed below apply to the 2017-2018 school year only.

MEDICAL

☐ **I elect to participate in the Anthem Blue Cross H.S.A. Plan $2000/$4000 with Rx copay $5/$20/$35 after deductible.**

The cost of this plan per pay period:

Medical with Rx (per 18 pays Sept-May):

☐	Single:	$62.75
☐	2 Person:	$125.50
☐	Family:	$169.42

If you need to add, delete or change individuals on your medical insurance, please visit the vernonpublicschools.org website to print an Anthem enrollment form, complete and submit with this election sheet.

H.S.A. – I elect the following to be deducted from my bi-weekly paycheck to be deposited into my HSA Account ****complete only if this is your first time with our H.S.A or if you elect to change your deduction, if left blank current deduction will stay remain the same.*** **$_____*Board annual contribution to the employee's H.S.A. account is $1,000 single $2,000 2person or family***

DENTAL

☐ **I elect to participate in the Anthem Blue Cross Dental Plan**

The cost of this plan per pay period:

Dental (per 18 pays Sept-May):
w/ ABC riders

☐	Single:	$7.35
☐	2 Person:	$20.60
☐	Family:	$25.00

If you need to add, delete or change individuals on your medical insurance, please visit the vernonpublicschools.org website to print an Anthem enrollment form, complete and submit with this election sheet.

For descriptive Coverage and Benefit Summary Information please visit the VPS website.

Return this form to Central Office, Attn: Cindy Schnell by June 2, 2017.

ALL EMPLOYEES WHO PARTICIPATE IN THE VPS HEALTH BENEFITS MUST COMPLETE THIS FORM, IF YOU WAIVE COVERAGE PLEASE COMPLETE THE INSURANCE WAIVER FORM POSTED ON VPS WEBSITE

I understand the above agreement and have selected a health benefit plan accordingly:

_____

Employee Name (print)

_____ _____

Employee Signature Date

☐ I understand and agree that electronically signing this document is the legal equivalent of a manual signature