



VERNON PUBLIC SCHOOLS

CAFETERIA

Selection of Benefits – Open Enrollment
(Effective 07/01/16)

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 2016-2017 rates and provider listed below apply to the 2016-2017 school year only.

MEDICAL

I elect to participate in the ConnectiCare H.S.A. Plan \$2000/\$4000

No changes in coverage **If checked do not select below**

Medical with Rx (per 18 pays, Sept-May):	<input type="checkbox"/> Single:	\$87.64
	<input type="checkbox"/> 2 Person:	\$175.29
	<input type="checkbox"/> Family:	\$236.64

If you need to add, delete or change individuals on your medical insurance, please visit the vernonpublicschools.org website to print a Connecticare 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 Health Equity 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

No changes in coverage **If checked do not select below**

Co-pay Basic (per 18 pays, Sept-May):	<input type="checkbox"/> Single:	\$13.54
Dental	<input type="checkbox"/> 2 Person:	\$37.93
	<input type="checkbox"/> Family:	\$46.05

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

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

Return this form to Central Office, Attn: Cindy Schnell by May 27th, 2016

I elect to waive health insurance coverage with Vernon Public Schools and agree to complete and submit an insurance waiver form.

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.