



VERNON PUBLIC SCHOOLS

TEACHER

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 with Rx copay \$5/\$20/\$35 after deductible.

No changes in coverage If checked do not select below

The cost of this plan per pay period:

Medical with Rx (per 18 pays Sept-May):	<input type="checkbox"/> Single:	\$58.07
	<input type="checkbox"/> 2 Person:	\$116.14
	<input type="checkbox"/> Family:	\$156.78

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

The cost of this plan per pay period:

Dental (per 18 pays Sept-May):	<input type="checkbox"/> Single:	\$8.06
w/ ABC riders	<input type="checkbox"/> 2 Person:	\$22.57
	<input type="checkbox"/> Family:	\$27.41

I do not require insurance and elect CASH IN LIEU in the amount of \$1,000

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

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