

VERNON PUBLIC SCHOOLS



30 Park Street • P.O. Box 600

Vernon, CT 06066-0600

Tel: 860-870-6000

This year's open enrollment period will be held Monday, May 23rd through Friday, June 17, 2011. Corporate Benefit Consultants and insurance representatives will be available to discuss the plans with you and to answer any questions you may have. The meeting times and locations are:

Tuesday May 24th 2:30-4:30pm Vernon Center Middle School Library

Wednesday June 1st 3:00-4:30pm Center Road School Library

Wednesday June 8th 2:30-4:30pm Central Administration - 2nd Floor Conf Room

The Open Enrollment forms and CIGNA information will be available on the Vernon Public Schools website or contact the Betty King. To access the forms and CIGNA information:

- Go to www.vernonschools.com
- Choose "**Departments**" from the menu on the left side and then "**Insurance and Benefits**" from the list of Office/Departments. Summary plan descriptions are available here as well.
- Select the folder for your bargaining unit

CHECK LIST:

- **Everyone** must complete the Employee Benefit Selection Form
- The following forms need to be completed if you are changing your election:

Pre-Tax Cost Sharing

CIGNA medical insurance enrollment

Anthem dental insurance enrollment

- **Complete CIGNA Life insurance enrollment form only** if you wish to change beneficiaries.

Coverage will be effective July 1, 2011. For active employees, medical and dental cost share deductions will begin October 2011 and continue through June 2012 in eighteen (18) equal installments. Bills for retirees will be mailed to you once your open enrollment forms are received in the business office.

Please contact Betty King (860/870-6000 x-128) with questions about Open Enrollment.

Complete, sign, date and return your Open Enrollment forms to Betty King by June 17th, 2011.

VERNON PUBLIC SCHOOLS

EMPLOYEE BENEFIT PACKAGE SELECTION FORM

**** CUSTODIANS, MAINTENANCE STAFF AND SECRETARIES AFSCME LOCAL 1303-35 ****

I hereby elect to enroll in the following plans:

INSURANCE BENEFIT SELECTION COVERAGE OPTIONS		ENROLLMENT CHOICES
LIFE INSURANCE	GROUP TERM LIFE INSURANCE (\$30,000)	Board Provided No Action Necessary
HEALTH & DENTAL CHOICES	I elect CASH IN LIEU OF HEALTH INSURANCE	Circle one: YES NO
	CIGNA OAP	Circle one: Individual or 2-person or Family
	FULL BASIC DENTAL	Circle one: Individual or 2-person or Family
	DENTAL RIDERS ABCD	Circle one: Individual or 2-person or Family
PRE-TAX	PRE-TAX COST SHARING -Premium Conversion	Circle one: YES NO

Should you desire to change your Employee Benefit Package during the year by adding/reducing coverage or waiving your right to health insurance coverage and electing to receive cash payments, these changes will take effect within sixty (60) days after the Business Office is notified in writing. Some changes can be retroactive (such as the birth of a child) & your cost sharing would be adjusted accordingly. **THIS FORM MUST BE SIGNED & RETURNED TO BETTY KING.**

Employee Name (printed)

Employee Social Security Number

Employee Signature

Date

VERNON BOARD OF EDUCATION
PRE-TAX COST SHARING (Premium Conversion)
Enrollment Agreement

The Vernon Board of Education participates in a pre-tax cost sharing plan under Section 125 of the Internal Revenue Code. Under this plan, the portion of your income that will be used to pay for your share of your medical benefits (otherwise known as your cost sharing amount) will be deducted from your gross pay. If you elect to participate, your contribution towards your **medical insurance** is treated as pre-tax income and therefore not subject to income tax, social security or Medicare tax.

Please make your election below, sign and return the form to Betty King, Vernon Board of Education.

NAME: _____

SOCIAL SECURITY NUMBER: _____

_____ I elect to make my contributions towards my **medical coverage** under the Vernon Board of Education Pre-Tax Cost Sharing Plan (Premium Conversion).

_____ I prefer to make my **medical coverage** contributions on an after tax basis.

I and the Vernon Board of Education, agree that my pay will be reduced by the amount of my required contribution for the benefit option (s) I have elected under the Pre-Tax Cost Sharing Plan (Premium Conversion)

I understand that I cannot change or revoke this benefit election or salary reduction agreement as of any date prior to the next enrollment period unless I have a change in family status (i.e., marriage, divorce, death of a spouse or child, birth or adoption of a child, termination of employment of a spouse) or other event for which a change or revocation of an election is permitted.

Employee's Signature _____ Date _____

Accepted and agreed to by the Vernon Board of Education _____

MEDICAL INSURANCE

Secretary/Custodians/Maintainers

Please choose between the medical plans offered below. The summary plan descriptions are available on the Vernon Public Schools website or by request from Betty King.

CIGNA \$20 OAP PLAN AND MEDCO DRUG PLAN \$10/\$20/\$30

	Single	2 Person	Family
Monthly Rate for Cigna	\$ 528.49	\$ 1,056.91	\$ 1,426.83
Monthly Rate for Medco	\$ 126.26	\$ 277.76	\$ 353.52
Total Monthly Rate	\$ 654.75	\$ 1,334.67	\$ 1,780.35
Total Annual Cost	\$ 7,857.00	\$ 16,016.04	\$ 21,364.20
Employee cost share %	15%	15%	15%
Total Employee cost per year	\$ 1,178.55	\$ 2,402.41	\$ 3,204.63
Employee payroll deduction 18 pays October through June	\$ 65.48	\$ 133.47	\$ 178.04

Enrollment / Change Form

Insured and/or Administered by
 Connecticut General Life Insurance
 Company
 CIGNA HealthCare

Employer: Complete SHADED sections
 Employee: Complete NON-SHADED sections

<input type="checkbox"/> New Enroll <input type="checkbox"/> Change <input type="checkbox"/> Termination	Effective Date	Employer Name Vernon Public Schools	Employer Address PO Box 600, 30 Park Street, Vernon, CT 06066
Account Number 3333373	Branch Code	Medical Benefit Option Code	Vision Benefit Option Code VISI

Employee Name (last)		(first)	(M.I.)	Social Security Number		
Employee Date of Birth (MM/DD/YYYY)	Home Phone	Work Phone	Home E-Mail Address (optional)			
Address (Street)		(City)	(State)	(Zip Code)		
Last Name	First Name	M.I.	Date of Birth	Gender	Coverage Selection	Social Security Number (required)
Employee	SAME AS ABOVE		SAME AS ABOVE	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Medical	SAME AS ABOVE
Spouse (whom you wish to cover)				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Medical	
Dependent (whom you wish to cover)				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Medical	
Dependent (whom you wish to cover)				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Medical	
Dependent (whom you wish to cover)				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Medical	

Plan Options Open Access Plus Plan (OAP) \$20 Copay Plan

Other Health Care Coverage
 Do you or your dependents have other health insurance under a group plan, HMO or Medicare? Yes No If yes, please provide the following:

Name of person covered	Social Security or Medicare No.	Effective Date	Medicare Part A	Medicare Part B	Medicaid	Insurance Carrier
1.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CIGNA HealthCare Provisions

"CIGNA HealthCare" refers to various operating subsidiaries of CIGNA Corporation. Products and services provided by these subsidiaries and not by CIGNA Corporation. These subsidiaries include Connecticut General Life Insurance Company, Tel-Drug, Inc. and its affiliates, CIGNA Behavioral Health, Inc., Intracorp, and HMO or service company subsidiaries of CIGNA Health Corporation and CIGNA Dental Health, Inc.
 I agree, for myself and my dependents, that, in the event any health services provided are the primary responsibility of any other party by way of other group health coverage or by the act or omission of another person to fully inform the healthplan and will execute such assignments, liens or other documents which may be necessary to enable the healthplan to recover the value of the services provided. I further agree that in the event I or any of my dependents collect benefits or damages from any other party who has primary responsibility for services provided by the healthplans I will immediately reimburse the healthplan to the extent of services provided to the extent permitted by state law.

RAUD WARNING

any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading information concerning any material fact thereto commits a fraudulent insurance act.

AUTHORIZATION TO DEDUCT CONTRIBUTIONS

authorize deductions from my earnings of the required contributions, if any, toward the cost of the coverage. This authorization applies only if employee contributions are required.

SPECIAL PROVISION FOR EMPLOYERS WITH SECTION 125 PLANS

by allowing an individual to enroll in the Insurance Plan other than during the open enrollment period, CIGNA HealthCare or Connecticut General Life Insurance Company does not waive any terms of its contract. Further, by allowing an individual to enroll in the Insurance Plan other than during the open enrollment period, CIGNA HealthCare or Connecticut General Life Insurance Company does not thereby express any opinion regarding the appropriateness of the change under Section 125 of the Internal Revenue Code or the terms of the employer's Section 125 plan.

Signature - The information provided above is true and correct to the best of my knowledge, and I accept the provisions above which I have read and understand.	
Employee's Signature/ Date	Employer's Signature / Date

DENTAL INSURANCE - ANTHEM

Secretary/Custodians/Maintainers

May elect full basic dental or full basic dental plus riders ABCD

Dependents are covered to age 19

Full Basic Dental

	Single	2 Person	Family
Monthly Rate For full basic dental	\$ 26.43	\$ 74.01	\$ 89.87
Total Annual Cost	\$ 317.16	\$ 888.12	\$ 1,078.44
Employee cost share %	15%	15%	15%
Total Employee cost per year	\$ 47.57	\$ 133.22	\$ 161.77
Employee payroll deduction 18 pays October through June	\$ 2.64	\$ 7.40	\$ 8.99

Full Basic Dental plus riders ABCD

	Single	2 Person	Family
Monthly Rate For full basic dental	\$ 26.43	\$ 74.01	\$ 89.87
Monthly Rate for riders ABCD	\$ 14.57	\$ 40.79	\$ 53.06
Total Monthly Rate	<u>\$ 41.00</u>	<u>\$ 114.80</u>	<u>\$ 142.93</u>
Total Annual Cost	\$ 492.00	\$ 1,377.60	\$ 1,715.16
Employee cost share 15% basic, 100% riders	15%/100%	15%/100%	15%/100%
Total Employee cost per year	\$ 222.41	\$ 622.70	\$ 798.49
Employee payroll deduction 18 pays October through June	\$ 12.36	\$ 34.59	\$ 44.36



In Connecticut, Anthem Blue Cross and Blue Shield is a trade name of Anthem Health Plans, Inc., an independent licensee of the Blue Cross and Blue Shield Association. © Registered marks of the Blue Cross and Blue Shield Association.

Enrollment and Membership Change Form

1. Tell Us About You		Current Anthem BCBS Contract Number, if any		2. New Membership		To Be Completed By Employer	
Last Name		First Name		<input type="checkbox"/> NEW HIRE <input type="checkbox"/> OPEN ENROLLMENT <input type="checkbox"/> COBRAC.G.S. 38a-538 DATE OF QUALIFYING EVENT _____ / _____ / _____		Requested Effective Date _____ / _____ / _____	
Home Address: Number and Street or P.O. Box		Apt. #		REASON <small>SEE INSTRUCTION SHEET</small>		Firm Division No.	
City		State		<input type="checkbox"/> NEW GROUP (ORIG ENROLLMENT) 3. Change Membership CHANGE: <input type="checkbox"/> ADDRESS <input type="checkbox"/> NAME <input type="checkbox"/> OTHER REASON _____ DATE _____ / _____ / _____		005241 -	
Home Telephone ()		Work Telephone ()				Health Benefit Plan	
MARITAL STATUS		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Legally Separated <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				For Office Use Only	

4. Your Membership Choices			Are you or any other eligible dependent listed on this form currently confined to a hospital or other healthcare facility, totally disabled or physically impaired? <input type="checkbox"/> YES <input type="checkbox"/> NO		
<input type="checkbox"/> DENTAL W/ riders ABCD circle yes or no			5. Where You Work COMPANY NAME VERNON PUBLIC SCHOOLS		
<input type="checkbox"/> Individual <input type="checkbox"/> Two Person <input type="checkbox"/> Family			ARE YOU ACTIVELY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO / (IF NO) REASON <input type="checkbox"/> SICK <input type="checkbox"/> INJURED <input type="checkbox"/> OTHER ARE YOU CURRENTLY CLAIMING WORKERS' COMP. MEDICAL BENEFITS? <input type="checkbox"/> YES <input type="checkbox"/> NO DO YOU WORK 30 OR MORE HOURS PER WEEK? <input type="checkbox"/> YES <input type="checkbox"/> NO		
DATE OF FULL TIME HIRE		DATE OF PART TIME HIRE		DATE OF REHIRE	

6. List Members To Be Added/Cancelled				Add		Cancel		Social Security Number		Date of Birth (MM/DD/YYYY)		Full Time Student Age 18 or Over		BELOW PLEASE INDICATE NAME OF RECOGNIZED INSTITUTION FOR FULL TIME STUDENTS		Primary Care Physician (PCP) Name (Refer to Provider Directory or www.anthem.com)				
SEX	NAME (FIRST/MIDDLE/LAST NAME)																	Check <input checked="" type="checkbox"/> the box if you currently use this physician.		
<input type="checkbox"/> M	Self																	Name	PCP Provider No.	<input type="checkbox"/>
<input type="checkbox"/> F																		City		
<input type="checkbox"/> M	Spouse																	Name	PCP Provider No.	<input type="checkbox"/>
<input type="checkbox"/> F																		City		
DEPENDENTS: Children over 19 may be eligible if disabled, or unmarried/full-time students. Please circle disabled dependent.																				
<input type="checkbox"/> M	Dependent																	Name	PCP Provider No.	<input type="checkbox"/>
<input type="checkbox"/> F																		City		
<input type="checkbox"/> M	Dependent																	Name	PCP Provider No.	<input type="checkbox"/>
<input type="checkbox"/> F																		City		
<input type="checkbox"/> M	Dependent																	Name	PCP Provider No.	<input type="checkbox"/>
<input type="checkbox"/> F																		City		

7. Tell Us About Your Other Insurance		Do you or any other member of your family have any other medical, dental, or Anthem BCBS coverage? <input type="checkbox"/> YES <input type="checkbox"/> NO					
		If yes, please fill in the information below. <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Children					
Name of Other Insurance Company		Name of Subscriber (Policyholder)		Policy or ID No.		Reason For Termination	First and Last Date of Coverage

8. Medicare/Medicaid		Do you or any covered member have Medicare/Medicaid coverage? <input type="checkbox"/> YES <input type="checkbox"/> NO									
		Have you or any covered member applied for Medicare/Medicaid disability? <input type="checkbox"/> YES <input type="checkbox"/> NO									
Name (Self)		Are you actively at work?		Retirement Date		Name (Dependent)		Is this person actively at work?		Retirement Date	
		<input type="checkbox"/> YES <input type="checkbox"/> NO		_____ / _____ / _____				<input type="checkbox"/> YES <input type="checkbox"/> NO		_____ / _____ / _____	
Medicare No.		Medicare A (Hospital)		Effective Dates		Medicare B (Medical)		Medicare No.		Medicare A (Hospital)	
		_____ / _____ / _____		_____ / _____ / _____						_____ / _____ / _____	

I understand that false and/or incomplete responses or statements may result in rescission of coverage and/or non-payment of claims for myself or my eligible dependents. I understand a copy of this application is provided to me as part of my Subscriber Agreement or health benefit plan document as applicable and is incorporated by reference therein. I certify that my statements in this form are true and complete to the best of my knowledge and belief.

9. Employee Signature		Date	
admin superv scm		_____ / _____ / _____	



Vernon Public Schools

BENEFIT ENROLLMENT FORM
BASIC & VOLUNTARY LIFE, ACCIDENT & DISABILITY INSURANCE

BENEFIT EFF. DATE:

HIRE DATE:

EMPLOYEE NAME (Last, First):

EMPLOYEE INFORMATION
EMPLOYEE NAME: DIVISION: DATE OF HIRE: DATE OF BIRTH:
ADDRESS: HOME PHONE: WORK PHONE: SEX:
CITY, STATE, ZIP: SOCIAL SECURITY NUMBER: MARITAL STATUS:

BASIC LIFE/AD&D, VOLUNTARY LIFE & LTD

BASIC LIFE & ACCIDENT INSURANCE: VOLUNTARY LIFE INSURANCE:
BASIC LONG TERM DISABILITY:

BENEFICIARY DESIGNATION: Unless you designate a percentage, proceeds are paid to primary surviving beneficiaries in equal shares.

Table with 5 columns: Primary Beneficiary (ies), Relationship, SSN, Date of Birth, Total must =100%. Includes sections for Basic & Voluntary Life Insurance and Basic Accident Insurance.

Table with 5 columns: Primary Beneficiary (ies), Relationship, SSN, Date of Birth, Total must =100%. Includes sections for Basic & Voluntary Life Insurance and Basic Accident Insurance.

Community Property Laws: If you are married, reside in a community property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington or Wisconsin), and name someone other than your spouse as beneficiary, it is possible that payment of benefits may be delayed or disputed unless your spouse also signs in beneficiary designation.

Spouse Signature: Date:
I accept the insurance coverages elected above. If premiums are to be paid by payroll, I authorize my employer to deduct the necessary amounts from my earnings.

EMPLOYEE SIGNATURE: DATE: