TOWN OF GLASTONBURY
Benefits Election Form
2014-2015 Plan Year

IUOE

Medical Plan Options	Annual Premiums	Date of Hire before 7/1/2004 Bi-Weekly Employee Contribution	Date of Hire After 7/1/2004. Connecticare HMO is Benchmark. Bi-Weekly Employee Contribution	Date of Hire After 2/1/2013. Connecticare HMO is Benchmark Plan Bi-Weekly Employee Contribution
Connecticare HMO				
Single	7,169.76	44.12	44.12	55.15
Double	15,630.00	96.18	96.18	120.23
Family	19,358.16	119.13	119.13	148.91
Connecicare Flex POS				
Single	7,867.92	48.42	70.97	82.00
Double	17,152.08	105.55	154.72	178.77
Family	21,243.48	130.73	191.64	221.42
Connecticare HDHP				
Single	6,858.48	42.21	42.21	52.76
Double	14,748.96	90.76	90.76	113.45
Family	17,730.36	109.11	109.11	136.39
Anthem PPO*				
Single	9,594.24	59.04	137.37	Not Available
Double	20,915.52	128.71	299.47	Not Available
Family	25,905.12	159.42	370.94	Not Available

***This plan is only offered to the individuals enrolled as of 7/1/2009**

Choose your Medical Insurance Plan:
( ) Connecticare HMO ( ) Connecticare Flex POS ( ) Connecticare HDHP ( ) Anthem PPO

Choose Your Level of Coverage:
( ) Single ( ) Double ( ) Family **Bi-weekly deduction amount $ _____**

Dental Plan Options

Full				
Single	653.28	4.02	4.02	5.03
Double	1,697.88	10.45	10.45	13.06
Family	2,096.28	12.90	12.90	16.13
Flex				
Single	747.48	4.60	4.60	5.75
Double	1,940.88	11.94	11.94	14.93
Family	2,136.24	13.15	13.15	16.43

Choose Your Dental Insurance Plan:
( ) Full ( )Flex

Choose Your Level of Coverage:
( ) Single ( ) Double ( ) Family **Bi-weekly deduction amount $ _____**

I understand that my contributions toward medical and/or dental premiums will be taken out on a pre-tax basis in accordance with Secion 125, Section 105, and/or Section 129 of the Internal Revenue Code. I understand I am bound by the terms of this agreement until my employment terminates, a qualifying event occurs, my benefits change at the beginning of a new plan year, or my employer terminates, suspends, or modifies a plan. If a qualifying event occurs, you MUST notify Human Resources in wirting, of such a change within 30 days of the qualifying event date.

☐ I am declining the medical or the medical and dental plan options offered above at this time. The annual Medical Opt-Out Cash Benefit is $1000. A Bi-weekly amount of $38.46 will be added to my paycheck.

Date of Hire _____

Name (Print) _____ Signature _____