TOWN OF GLASTONBURY

2011-2012 Plan Year Benefits Election Form

Circle the appropriate BI-WEEKLY plan choices, indicated in the column corresponding to your date of hire; sign and date this form.

Benchmark Plans indicated with **

GPOA	Annual Premiums Date of Hire before 7/1/2009	Date of Hire before 7/1/03 Bi-Weekly Employee Contributions	Benchmark Plan Date of Hire after 2/18/2003 Bi-Weekly Employee Contributions	Annual Premiums Date of Hire on/after 7/1/2009	Benchmark Plan Date of Hire after 7/1/2009 Bi-Weekly Employee Contributions
Medical Plan Options					
CTCare HMO Single **	6,473.40	34.86	34.86	6,322.08	34.04
CTCare HMO Double **	14,112.00	75.99	75.99	13,782.12	74.21
CTCare HMO Family **	17,478.24	94.11	94.11	17,069.64	91.91
CTCare HDHP Single	5,551.80	29.89	29.89	5,551.80	29.89
CTCare HDHP Double	11,900.40	64.08	64.08	11,900.40	64.08
CTCare HDHP Family	14,202.36	76.47	76.47	14,202.36	76.47
Anthem PPO Single	7,153.44	38.52	61.01	7,134.84	65.30
Anthem PPO Double	14,557.80	78.39	93.13	14,516.76	102.47
Anthem PPO Family	18,479.28	99.50	132.62	18,427.56	144.14
Anthem POS Single	7,799.16	42.00	85.85	7,723.56	87.95
Anthem POS Double	16,210.56	87.29	156.70	16,030.56	160.69
Anthem POS Family	20,512.68	110.45	210.82	20,289.24	215.74
Anthem HDHP- Single	6,982.44	37.60	37.60	6,982.44	37.60
Anthem HDHP- Double	13,964.64	75.19	75.19	13,964.64	75.19
Anthem HDHP- Family	17,142.84	92.31	92.31	17,142.84	92.31
Dental Plan Options					
Employee (Single)		2.56	2.56		2.56
Employee + 1 (Double)		6.64	6.64		6.64
Employee + Family (Family)		8.21	8.21		8.21
Flex Dental					
Employee (Single)		2.92	2.92		2.92
Employee + 1 (Double)		7.59	7.59		7.59
Employee + Family (Family)		8.36	8.36		8.36

☐ I am declining all medical & 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.

I understand that my contribution toward medical and/or dental premiums will be taken out on a pre-tax basis in accordance with Section 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 change occurs, my benefits change at the beginning of a new plan year or my employer terminates, suspends, or modifies the plan.

Name _____ **Date of Hire** _____

Signature _____ **Date** _____