TOWN OF GLASTONBURY
Benefits Election Form
2013-2014 Plan Year

Non Affiliated

Medical Plan Options	Date of Hire before 7/1/2009. Benchmark Plan Connecticare HMO Annual Premiums	Bi-Weekly Employee Contribution	Date of Hire After 7/1/2009. Benchmark Plan Connecticare HDHP Annual Premiums	Bi-Weekly Employee Contribution
Connecticare HMO				
Single	7,587.96	37.94	7,411.92	58.60
Double	16,541.76	82.71	16,158.24	134.53
Family	20,487.48	102.44	20,012.40	184.58
Connecicare Flex POS				
Single	8,149.44	59.54	7,973.52	80.20
Double	17,765.88	129.79	17,382.24	181.61
Family	22,003.80	160.76	21,528.60	242.89
Connecticare HDHP				
Single	6,768.24	33.84	6,768.24	33.84
Double	14,552.16	72.76	14,552.16	72.76
Family	17,486.52	87.43	17,486.52	87.43
Anthem PPO				
Single	9,860.52	125.35	Not Offered	
Double	21,495.84	273.25	Not Offered	
Family	26,623.32	338.43	Not Offered	
Anthem HDHP				
Single	9,136.44	45.68	9,136.44	124.92
Double	19,714.92	98.57	19,714.92	271.33
Family	23,880.72	119.40	23,880.72	333.36

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

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

Dental Plan Options				
Full				
Single	625.80	3.13		3.13
Double	1,626.36	8.13		8.13
Family	2,007.96	10.04		10.04
Flex				
Single	715.92	3.58		3.58
Double	1,859.04	9.30		9.30
Family	2,046.00	10.23		10.23

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 $1500. A Bi-weekly amount of $57.69 will be added to my paycheck.

Date of Hire _____ **Signature** _____

Name (Print) _____ **Date** _____