TOWN OF GLASTONBURY
Benefits Election Form
2013-2014 Plan Year

AFSCME

		Date of Hire before 11/29/2005	Date of Hire on/after 11/29/2005. Connecticare HMO is Benchmark Plan
Medical Plan Options	**Annual Premiums**	**Bi-Weekly Employee Contribution**	**Bi-Weekly Employee Contribution**
Connecticare HMO			
Single	7,712.64	45.24	45.24
Double	16,813.92	98.62	98.62
Family	20,824.44	122.14	122.14
Anthem PPO			
Single	8,559.36	50.20	77.81
Double	18,659.64	109.45	169.61
Family	23,110.44	135.55	210.06

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

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

Dental Plan Options			
Full			
Single	625.80	3.67	3.67
Double	1,626.36	9.54	9.54
Family	2,007.96	11.78	11.78
Flex			
Single	715.92	4.20	4.20
Double	1,859.04	10.90	10.90
Family	2,046.00	12.00	12.00

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.

Date of Hire _____ **Signature _____**

Name (Print) _____ **Date _____**