

TOWN OF GLASTONBURY
Benefits Election Form
2013-2014 Plan Year

IUOE

Medical Plan Options	Annual Premiums	Date of Hire before 7/1/2004	Date of Hire After 7/1/2004.	Date of Hire After 2/1/2013.
		Bi-Weekly Employee Contribution	Connecticare HMO is Benchmark. Bi-Weekly Employee Contribution	Connecticare HMO is Benchmark Plan Bi-Weekly Employee Contribution
Connecticare HMO				
Single	7,587.96	43.78	43.78	58.37
Double	16,541.76	95.43	95.43	127.24
Family	20,487.48	118.20	118.20	157.60
Connecticare Flex POS				
Single	8,326.92	48.04	72.20	59.46
Double	18,152.64	104.73	157.39	129.62
Family	22,482.72	129.71	194.94	160.55
Connecticare HDHP				
Single	6,768.24	39.05	39.05	39.05
Double	14,552.16	83.95	83.95	83.95
Family	17,486.52	100.88	100.88	100.88
Anthem PPO*				
Single	9,860.52	56.89	131.19	Not Available
Double	21,495.84	124.01	285.97	Not Available
Family	26,623.32	153.60	354.19	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	625.80	3.61	3.61	4.81
Double	1,626.36	9.38	9.38	12.51
Family	2,007.96	11.58	11.58	15.45
Flex				
Single	715.92	4.13	4.13	5.51
Double	1,859.04	10.73	10.73	14.30
Family	2,046.00	11.80	11.80	15.74

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 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 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 writing, 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

Date of Hire _____
 Name (Print) _____ Signature _____