



Employee name: \_\_\_\_\_

# VPS Benefits Election 2023-2024

Group: Librarian

Coverage Period: 7/1/23 – 6/30/24

## Benefits available to you in 2023-24:

- **Medical Insurance:** Cigna Open Access Plus High Deductible Health Plan w/ HSA  
2023-24 Cost: **Single** - \$100.30 per pay    **2-Person** - \$200.60 per pay    **Family** - \$270.80 per pay
- **Dental Insurance:** Anthem Basic Dental  
2023-24 Cost: **Single** - \$3.86 per pay    **2-Person** - \$10.81 per pay    **Family** - \$13.13 per pay
- **Additional Buy-Up Dental Insurance:** Anthem Dental Riders ABC  
2023-24 Cost: **Single** - \$2.70 per pay    **2-Person** - \$7.57 per pay    **Family** - \$10.31 per pay
- **Vision Insurance:** Anthem Blue View Vision  
2023-24 Cost: **Single** - \$3.77 per pay    **2-Person** - \$6.60 per pay    **Family** - \$10.56 per pay
- **Flexible Spending Account** – Dependent Care Account and/or Medical Care Account  
For information & forms, go to: [www.vernonpublicschools.org/departments/human-resources/insurance](http://www.vernonpublicschools.org/departments/human-resources/insurance)

## Make your choices for the 2023-24 benefits! Choose below.

- I'm making no changes to my benefit for the 2023-24 plan year. Keep everything the same.
- Cancel the following benefit (medical, dental, vision, etc.): \_\_\_\_\_.
- I would like to enroll in a new benefit. Mark your choice below & send HR a completed enrollment form by **May 31, 2023**:  
       \_\_\_ Medical    \_\_\_ Dental    \_\_\_ Dental Buy-Up    \_\_\_ Vision    \_\_\_ Flex Spending Acct
- I would like to add or cancel a dependent on my insurance (send HR a completed enrollment form by **May 31, 2023**). Explain your change: \_\_\_\_\_

I certify that I have read the benefits summary and understand the benefits for which I am enrolling. I authorize my employer to make any changes noted above to my current benefit elections and to deduct from my salary the amount necessary to pay for the insurance I chose.

Such elections will remain in effect until one of the following occurs: employment ends, I elect changes in a new plan year or consistent with a qualifying event (i.e., marriage, divorce, birth, death, loss of coverage, etc.), or my employer modifies the plan. The rates and carriers shown above apply to the 2023-2024 plan year only.

I understand the above agreement.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

- I agree that my electronic signature is the legal equivalent of a manual signature.

**Forms must be RECEIVED in Human Resources by May 31, 2023**