



Employee name: _____

VPS Benefits Election 2023-2024

Group: Nurse

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** - \$109.84 per pay **2-Person** - \$219.68 per pay **Family** - \$296.57 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 Rider A
2023-24 Cost: **Single** - \$1.79 per pay **2-Person** - \$5.01 per pay **Family** - \$6.08 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

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