Employee name: _____

VPS Benefits Election 2023-2024

Coverage Period: 7/1/23 – 6/30/24

Group: Supervisor

Benefits available to you in 2023-24:

- **Medical Insurance: Cigna** *Open Access Plus High Deductible Health Plan w/ HSA*

  2023-24 Cost: **Single** - $94.14 per pay **2-Person** - $188.27 per pay **Family** - $254.17 per pay

- **Dental Insurance: Anthem** *Full 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 ABCD*

  2023-24 Cost: **Single** - $8.83 per pay **2-Person** - $24.73 per pay **Family** - $33.40 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.

Clear Form

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

Rev. 5.11.23