

Town of Ellington Health, Dental and Vision Benefit Election Form

State of Connecticut Partnership Plan (POS)

Plan Year July 1, 2023 to June 30, 2024

All benefit-eligible employees must complete this form and return it to Human Resources even if you choose to decline benefits for FY2023-2024.

(Open Enrollment is being held again in June 2023 for the July 1, 2023-June 30, 2024 Plan Year as we transition from the calendar year to the fiscal year for budgeting purposes. Subsequently, Open Enrollment will be held annually in June.)

Vendor	Plan Name	Coverage	Semi-Monthly Town Pays	Semi Monthly Employee Pays	Your Selection(s) Check box(s)
Anthem	Health Insurance	Employee Only	\$450.09	\$70.25	<input type="checkbox"/>
		Employee + 1	\$962.69	\$150.25	<input type="checkbox"/>
		Employee + Family	\$1,176.29	\$183.58	<input type="checkbox"/>
Cigna	Dental Insurance	Employee Only	\$20.20	\$ 3.15	<input type="checkbox"/>
		Employee + 1	\$44.43	\$6.93	<input type="checkbox"/>
		Employee + Family	\$68.61	\$10.71	<input type="checkbox"/>
Cigna	Vision Coverage	Employee Only	\$3.90	\$0	<input type="checkbox"/>
		Employee + 1	\$7.23	\$0	<input type="checkbox"/>
		Employee + Family	\$11.78	\$0	<input type="checkbox"/>

Notes: Town Pays 86.5% of the Health and Dental plans for employees; employees pay 13.5%

Dependent children can be covered on health and dental insurance until the end of the calendar year in which age 26 is reached.

<input type="checkbox"/>	I agree to have my gross salary reduced in accordance with Section 125 of the Internal Revenue Code to cover my contributions toward the benefits I have selected above.
<input type="checkbox"/>	I am electing the benefits indicated with a check mark above, but do not want my contributions to be taken on a pre-tax basis.
<input type="checkbox"/>	I am declining all medical, dental and vision plan options offered at this time.
I understand that 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 the plan.	

Employee's Printed Name

Today's Date

Signature

Personal Email Address

RETURN TO HUMAN RESOURCES OR EMAIL TO LCANNELLA@ELLINGTON-CT.GOV BY JUNE 15, 2023

OFFICE USE ONLY:

Scanned to Finance/Payroll on ____/____/____