Vermont Department of Taxes PO Box 547 Montpelier, VT 05601-0547 Phone: (802) 828-2551

VT Form **HC-2**	**DECLARATION OF HEALTH CARE COVERAGE**	**This form must be completed annually by all uncovered employees. Employers must retain this form for 3 years.**

Employer: This form is **only** to be completed by employees if you offer to pay a portion of a health care plan that provides hospital and physicians services to at least some of your employees. You must retain all employee declaration forms together in a file for three years and be able to produce them in the event of an audit.

Employer's Legal Name ***(Please print)*** _____

Employee: Complete and sign this form and return it to your employer. The purpose of this form is to obtain information regarding your health care coverage. The information you provide on this form will be used solely for purposes of determining if your employer must pay Health Care Contributions as required under Vermont law at 32 V.S.A § 10503.

Employee's Full Name ***(Please print)***	
Employee ID or Social Security Number	**Date of Birth**

Will the employee be under the age of 18 for the entire calendar year? ☐ YES ☐ NO

If **YES**, stop. Please sign the bottom of the form and submit it to your employer.

If **NO**, please continue to complete this form and submit it to your employer.

Check the box beside the statement that best describes your health care coverage.

1. My employer offers health care coverage to me.

☐ I have accepted the health care coverage offered and provided by my employer.

2. My employer offers health care coverage to me, and I have <u>not</u> accepted my employer's coverage.

☐ I have health care coverage that includes hospital and physicians services from a source other than Medicaid or Vermont Health Benefit Exchange.

My coverage is provided through: _____

☐ I am a full-time employee and have health care coverage as an individual through the Vermont Health Benefit Exchange.

☐ I have Medicaid.

☐ I have no health care coverage.

3. My employer does <u>not</u> offer health care coverage to me.

☐ I am a part-time employee who works fewer than 30 hours per week, **<u>and</u>** I have coverage from a source other than Medicaid that offers hospital and physicians services.

☐ I am a seasonal employee who expects to work for this employer 20 or fewer weeks during this calendar year, **<u>and</u>** I have coverage from a source other than Medicaid that offers hospital and physicians services.

☐ I have health care coverage that offers hospital and physicians services.

My coverage is provided through: _____

☐ I am a part-time or seasonal employee, and I do not have health care coverage **<u>or</u>** I am covered by Medicaid.

☐ I have no health care coverage.

☐ **I certify the above information is accurate and true to best of my knowledge and belief.**

Employee Signature _____ Date _____

Note: If your health care coverage changes within the year, you must complete a new Declaration of Health Care Coverage.

BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association

VEHI
Enrollment and Change Form

Please provide all information and print in ink or type.

Please submit this form to your Central Office for processing.

Requested effective date ___/___/___

Section 1: EMPLOYER/EMPLOYEE INFORMATION

Employer name:		**Employee type:** ☐ Licensed ☐ Non-licensed ☐ Confidential/Municipal ☐ Private School/Other	
Group/division #: (office use only)		**Employment status:** ☐ Active ☐ Continuation (COBRA)	
Health plan selection: ☐ Platinum ☐ Gold ☐ Gold CDHP ☐ Silver CDHP			
Health coverage type: ☐ Employee only ☐ Employee/spouse (including party to a civil union/domestic partner) ☐ Employee/child(ren) ☐ Family			
Health care spending account: ☐ Health Reimbursement Arrangement (HRA): all plans ☐ Health Savings Account (HSA): For Public Schools Silver CDHP Only ☐ None/Opt-out			
Last name:	**First name:**		**Social Security number ****(SSN):**
Mailing address:			**PCP name** NPI No.***
City:	**State:**	**ZIP code:**	Are you a current patient? ☐ Yes ☐ No
Phone number:	**Email address:**		☐ resides outside of BCBSVT provider network (no PCP required)
Date of birth (DOB):	**Gender:** ☐ Male ☐ Female		**Marital status:** ☐ Single ☐ Married/party to a civil union ☐ Domestic Partner**

Section 2: NEW ENROLLMENT (Check one, then go to SECTION 4)

☐ Open enrollment ☐ New hire/re-hire ☐ Continuation of coverage (COBRA) ☐ Refusal ☐ Spouse turning age 65

☐ Transferred from another VEHI plan Transferring from member ID no.: ______________________

Section 3: CHANGE/CANCELLATION

Change: **Effective date** ___/___/_____

☐ Birth
☐ Adoption placement date ___/___/______
☐ Marriage/Civil Union
☐ Divorce
☐ Address change
☐ Name change
☐ PCP change
☐ Court ordered change**
☐ Loss of coverage**

Cancel: **Date of Cancellation** ___/___/______

☐ Voluntary cancel (signature required)

____

Proof of other insurance is required to complete this request if submitted outside of groups Open Enrollment period. Please include documentation when returning the form.

☐ Left employment (group benefits manager signature)

____

☐ Other (explain) ______________________________

Section 4: LIST ALL DEPENDENTS BELOW TO BE ADDED OR REMOVED

Dependent Information **** Important note: SSN required for all members			**Primary Care Provider (PCP) Information** (required)
☐ Add ☐ Remove (Spouse/party to a civil union/domestic partner) Last Name First Name	SSN*** DOB	Gender: ☐ Male ☐ Female	PCP Name NPI No.*** Are you a current patient? ☐ Yes ☐ No ☐ resides outside of BCBSVT provider network (no PCP required)
☐ Add ☐ Remove Last Name First Name	SSN*** DOB	Gender: ☐ Male ☐ Female	PCP Name NPI No.*** Are you a current patient? ☐ Yes ☐ No ☐ resides outside of BCBSVT provider network (no PCP required)
☐ Add ☐ Remove Last Name First Name	SSN*** DOB	Gender: ☐ Male ☐ Female	PCP Name NPI No.*** Are you a current patient? ☐ Yes ☐ No ☐ resides outside of BCBSVT provider network (no PCP required)
☐ Add ☐ Remove Last Name First Name	SSN*** DOB	Gender: ☐ Male ☐ Female	PCP Name NPI No.*** Are you a current patient? ☐ Yes ☐ No ☐ resides outside of BCBSVT provider network (no PCP required)
☐ Add ☐ Remove Last Name First Name	SSN*** DOB	Gender: ☐ Male ☐ Female	PCP Name NPI No.*** Are you a current patient? ☐ Yes ☐ No ☐ resides outside of BCBSVT provider network (no PCP required)

Please see section 6 on page 2 for employee signature

Employer name:	Employee name:

Section 5: OTHER INSURANCE INFORMATION

If you obtain health insurance coverage with us, will you or any of your dependents be covered with another health or dental insurance plan (including Medicare or Medicaid)?

☐ **Yes** ☐ **No**

MEDICAL	Insurance company (name and address)			DENTAL	Insurance company (name and address)		
	Policyholder name	Policy certificate no.	Group no.		Policyholder name	Policy certificate no.	Group no.
	Effective date	Type of coverage ☐ 1-person ☐ 2-person ☐ Family			Effective date	Type of coverage ☐ 1-person ☐ 2-person ☐ Family	

Section 6: SUBSCRIBER INFORMATION

I certify that the statements on this application and all information I've furnished is true and complete to the best of my knowledge. I authorize any health care provider to disclose to Blue Cross VT, or its designated agent, any information acquired in connection with my past or future care or treatment or that of any dependent named herein or hereafter added to my coverage. I understand that no right whatsoever is created by this application and that the same shall not be considered accepted unless and until the contract is actually issued by Blue Cross VT.

I UNDERSTAND THAT MY BENEFITS ARE GOVERNED BY THE PROVISIONS OF MY VEHI BENEFITS DESCRIPTION AND OUTLINE OF COVERAGE.

SIGN HERE

▶Employee's signature _____ Date _____◀

FOR OFFICE USE ONLY

Email: asinbox@bcbsvt.com	**Fax:** (802) 371-3329	**Mail:** Blue Cross VT P.O. Box 186 Montpelier, VT 05601-0186

If you are adding a dependent child, age 26 or older, contact customer service at (800) 344-6690 (TTY/TDD: 711) for further instructions.

* = Includes Party to a Civil Union or Domestic partner
** = Additional Documentation Required
*** = See our "Find-a-Doctor" tool at **bluecrossvt.org/find-doctor**
**** = SSN required for all members (Federal mandate requires the collection of SSN).

Sworn Statement of Alternative Health Insurance Coverage

Name:	Social Security Number:

The District Cafeteria Plan requires that you enroll in their group health insurance plan, unless you receive comparable alternative group health insurance coverage. If you have comparable alternative coverage, please complete the following, sign and return this form with proof of alternate permissible health plan coverage for yourself and, if applicable your spouse and eligible tax dependents to Human Resources. ***Enrollment in an "individually purchased plan," such as coverage from Vermont Health Connect is not an eligible alternative health insurance plan.*** Permissible health plan coverage may include Employer-sponsored plans, Medicare, Medicaid, CHIP, TRICARE, VA Coverage, Coverage for Peace Corps volunteers, or Civilian Employees of the U.S. Department of Defense.

Alternative Coverage
Plan Sponsor:
Insurance Company:
My coverage: (select one): ☐ Single; ☐ 2 Person; ☐ Family;
Effective for the 12-Month Period Beginning (Plan Year effective date): **Provide a copy of your health insurance ID Card and/or cards***

I certify that I am currently receiving comparable medical benefits as listed above. To the best of my knowledge this coverage is comparable to the health insurance provided by my employer. I understand that the Plan Administrator reserves the right to refuse this statement based on a finding that the alternative coverage is not comparable.

*I understand that I will not receive the "cash in lieu" if I do not supply proof of insurance coverage (health insurance ID Card and or other information as requested) for myself and, if applicable, my spouse and tax dependents. I understand that if my health insurance status changes during the Plan Year (January 1 – December 31), I must notify the District Human Resources department within 30 days.

Under penalty of perjury, I declare that the information I have furnished above, to the best of my knowledge and belief, is true, correct and complete.

Employee's Signature:	Date:
Authorized Delegate of the Plan Administrator:	Date:

Acceptable proof of alternative coverage shall include a copy of the employee's alternative medical insurance ID card indicating the employee's name as a dependent; a letter from the spouse/civil union partner's employer indicating the employee, spouse and dependents are covered under the plan; or, a letter from the alternative insurance carrier indicating proof of coverage.

IF YOU ARE A TEACHER OR AFSCME MEMBER AND ARE ELIGIBLE PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM. ⟹

Barre Unified Union School District ("District") Cafeteria Plan

Cash-in-lieu of Insurance Election of Benefits Form

(AFSCME MEMBERS, TEACHERS, ADMINISTRATORS & NON CONTRACTED EMPLOYEES ONLY)

Provisions of Act 7 as defined by 16 V.S.A. Chapter 61 states that school employees cannot receive CIL of health benefits if receiving health benefits from a school employer.

Name (Last, First MI)	Date
Social Security Number	Plan Year

Election to receive Employer Contribution as Cash

I am eligible for the Employer contribution because I am employed by the BUUSD under the American Federation of State, Country and Municipal Employees (AFSCME) or the Barre Education Association (teacher only) collective bargaining agreement and I am not electing health insurance benefits through the District (which I am eligible for), and I have other permissible health plan coverage for myself, and if applicable, my spouse and eligible tax dependents. (Please refer to the Sworn State of Alternative Health Coverage below for more details.)

I understand I will receive the employer contribution in one installment. Payment will be made at the end of Fiscal Year (June 30th of each Fiscal Year), on dates to be selected by my employer, **to be taxed as regular income**.

This agreement is subject to the terms of the District Cafeteria Plan, as amended from time to time in effect, shall be governed and construed in accordance with applicable laws, shall take effect as a sealed instrument under applicable laws, and revokes any prior election relating to such plan.

This election form is only valid for the Plan Year specified above. A new election must be made each Plan Year in which the employee wishes to participate.

A Sworn Statement of Alternative Health Insurance and proof of alternative insurance for the employee and all tax dependents must accompany this election form.

Employee's Signature:	Date:

Please complete the *Sworn Statement of Alternative Health Insurance Coverage* on the reverse side of this form ⟹

DELTA DENTAL

HOW HEALTH through ORAL WELLNESS

DENTAL ENROLLMENT / CHANGE FORM

Delta Dental Plan of Maine – Delta Dental Plan of New Hampshire – Delta Dental Plan of Vermont
Please send form to: eligibilitydepartment@nedelta.com or Eligibility Fax - (603) 223-1252
Northeast Delta Dental – One Delta Drive – PO Box 2002 – Concord, NH 03302-2002 – 1-800-537-1715 – nedelta.com - (603) 223-1230 Eligibility

Be sure to fill out each section completely. Failure to complete each section in full could delay processing.

1. GROUP INFORMATION - To be completed by Employer

Group Number:	Sublocation:	Division:	Misc. Info:	If Dual Option, Select Plan ☐ Low ☐ High ☐ N/A
Group Name:			Address:	

2. SUBSCRIBER INFORMATION – To be completed by Employee

Date of Hire: (MM-DD-YYYY)	Date of Rehire: (MM-DD-YYYY)	Subscriber Effective Date: (MM-DD-YYYY)	
Social Security No:	Last Name:	First Name:	
Date of Birth:	Sex: ☐ Female ☐ Male	Marital Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Widowed	
Mailing Address:	City:	State:	Zip:
Email Address:		Phone Number:	

3. ENROLLMENT OR CHANGE REQUEST

Exact Date of Change: (MM-DD-YYYY)

Coverage Level Requested: ☐ Subscriber Only ☐ Subscriber & Spouse ☐ Subscriber & Child ☐ Subscriber & Children ☐ Family

Reason for Change: ☐ Add ☐ Delete

- ☐ New Hire ☐ Open Enrollment ☐ Marriage ☐ Birth/Adoption ☐ COBRA ☐ Address Change ☐ Loss of Coverage ☐ Employment Change
- ☐ Name Change:
- ☐ Transfer from Sublocation:
- ☐ Other/Explain:

Will this dental coverage replace another Northeast Delta Dental Plan? If yes, provide the Subscriber ID/SSN and Name:

4. DEPENDENT INFORMATION

List all dependents to be newly enrolled, or those dependents who are affected by an addition or deletion. If you are enrolling some but not all your eligible dependents, your other dependents must have coverage elsewhere.

Last Name	First Name	Date of Birth (MM-DD-YYYY)	Sex	Relationship to Subscriber	*	Add/Remove	Email for Spouse and/or Dependents over the age of 18
			☐ F ☐ M	☐ Spouse ☐ Domestic Partner ☐ Child/Dependent	☐	☐ Add ☐ Remove	
			☐ F ☐ M	☐ Child/Dependent	☐	☐ Add ☐ Remove	
			☐ F ☐ M	☐ Child/Dependent	☐	☐ Add ☐ Remove	
			☐ F ☐ M	☐ Child/Dependent	☐	☐ Add ☐ Remove	
			☐ F ☐ M	☐ Child/Dependent	☐	☐ Add ☐ Remove	

*Check box if dependent is incapacitated. Legal documentation may be required.

Statements made in this document are deemed to be representations and not warranties. I represent that all information is true and correct to the best of my knowledge. I understand that by not choosing a network provider for myself or any family member, I may be responsible for higher out-of-pocket expenses. I also understand that the effective date and termination date of my membership will be determined by my employer or plan sponsor in accordance with the underwriting guidelines of Northeast Delta Dental. If my employer or plan sponsor requires employee contributions for this coverage, I authorize the deductions of these amounts from my wages. I further authorize my employer or plan sponsor to deduct any premium which is owed by me as of the date my application is approved. I understand that my dependents and I must remain enrolled and can discontinue our coverage only during open enrollment, except in the event of a qualified family status change. **By signing below I hereby accept coverage. This policy provides dental benefits only. Review your policy carefully.**

SUBSCRIBER SIGNATURE (REQUIRED): _____ DATE: _____

Please retain a copy for your records.

Enrollment Form with Dependent Data

Name of group (employer): _____

Employee last name, first name, middle initial: _____

Social Security Number: _____

Employee Home Address: _____

Email Address: _____ Date of birth (month/date/year): _____

Gender: ☐ male ☐ female

Type of coverage selected: ☐ employee only ☐ employee and one dependent ☐ employee and child(ren) ☐ employee and family ☐ waive coverage

Effective Date of Coverage: _____ *** Dependent Relationship**: S=spouse, C=child, H=handicapped child, T=student

dependent last name	dependent first name	gender	* Dependent Relationship	date of birth mm/dd/yyyy
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /

Employee Signature: _____

Please return this form to your benefits administrator. Do not return to VSP.

HRA Enrollment / Change Form

☐ ENROLLMENT ☐ CHANGE ☐ TERMINATION

School District:_____ ◯ Licensed ◯ Non-Licensed

First Name:		**Last Name:**	
Social Security Number:		**Date of Birth:**	
Phone Number	☐ Home ☐ Cell	**Email:**	
Effective Date:		**Mailing Address** *(please include city, state & zip code)*:	

DEPENDENT INFORMATION:

Last Name	First Name	SS #:	Date of Birth

*Note- To participate in the HRA plan, you must be enrolled in a health plan with minimum essential coverage through an employer. Individual health plans are not HRA compatible. You also may not *contribute* to a Health Savings Account without notifying Healthy Dollars as your HRA plan may need to be limited to dental and vision expenses only.

Authorization I hereby elect to participate in my employer's HRA plan agreeing to be bound by all terms, condition and limitations to the Plan. I understand that I must keep copies of all debit card transaction receipts and can be asked to submit them at any time through the plan year. I also agree that if I cannot produce a copy of the requested receipt, the transaction will be deemed ineligible and I will be required to refund the plan for the total expenses.

☐ I **ELECT** to participate in the Healthy Dollars HRA Plan ☐ I **DO NOT** elect to participate in the Healthy Dollars HRA Plan

Employee Signature: _____ Date: _____

*** **For Accurate Enrollment Please Write Clearly** ***

October 2020

FSA, LPFSA, DCA & HSA Enrollment / Change Form

☐ Enrollment ☐ Change ☐ Termination Employer: _____

First Name:		**Last Name:**	
Social Security Number:		**Date of Birth:**	
Phone Number	☐Home ☐Cell	**Email:**	
Effective Date:		**Mailing Address** *(please include city, state & zip code)*:	

Dependent Information:

Last Name	First Name	SS #:	Date of Birth

Election:

	Annual Election	Deduction Per Pay Period	First Payroll Date
Flexible Spending Account			
Limited Purpose FSA			
Dependent Care Account			
HSA**			

****Note- To participate in the HSA plan, you must also complete the Avidia Bank HSA Healthy Dollars Form.**

Authorization I hereby elect to participate in my employer's FSA and/or DCA plan agreeing to be bound by all terms, condition and limitations to the Plan. I understand that I must keep copies of all debit card transaction receipts and can be asked to submit them at any time through the plan year. I also agree that if I cannot produce a copy of the requested receipt, the transaction will be deemed ineligible and I will be required to refund the plan for the total expenses.

☐ I **ELECT** to participate in the Healthy Dollars Plan ☐ I **DO NOT** elect to participate in the Healthy Dollars Plan

Employee Signature: _____ Date: _____

*** **For Accurate Enrollment Please Write Clearly** ***

November 2021

Enrollment Form
United of Omaha Life Insurance Company

3300 Mutual of Omaha Plaza, Omaha, Nebraska 68175

Employer Section (To be completed by the employer. Required fields are marked with an asterisk(*).)

*Employer Name: Barre Supervisory Union		Effective Date:	Group ID: G000B5L5
Sub Group ID:	Location Code:	Class:	Occupation:
*Salary: ☐ Hourly ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Semi-Monthly ☐ Annually		*Date of Hire:	Hours Worked Per Week:

Employee Section (Please print clearly. Required fields are marked with an asterisk(*).)

*Last Name:	*First Name:		MI:
*SSN/ID Number:	*Birth Date (MM/DD/YYYY):	*Gender:	*Marital Status:
*Street Address:			
*City:	*State:	*Zip Code:	

Long-Term Disability Coverage Election

Employee Coverage Only	Enroll	Decline	Benefit Amount	Premium Amount
Long-Term Disability	☒	☐	_____ per Month	Paid by Employer

Basic Life and AD&D Coverage Election

Employee Coverage Only	Enroll	Decline	Benefit Amount	Premium Amount
Basic Life and AD&D - Employee	☒	☐	_____	Paid by Employer

Voluntary Life and AD&D Coverage Election

Employee and Dependent Coverage	Benefit Amount - Select One Option	Premium Amount
Voluntary Life and AD&D - Employee	☐ $20,000 ☐ $70,000 ☐ $100,000 ☐ $150,000 ☐ Other $_____ ☐ Decline	$_____ $_____ $_____ $_____ $_____
Voluntary Life and AD&D - Spouse	☐ $10,000 ☐ $20,000 ☐ $30,000 ☐ $35,000 ☐ Other $_____ ☐ Decline	$_____ $_____ $_____ $_____ $_____
Voluntary Life and AD&D - Child(ren)	☐ $10,000 (per child) ☐ Other $_____ ☐ Decline	$_____ $_____

You must complete and submit an Evidence of Insurability form if you or your spouse are enrolling for Voluntary Term Life coverage in excess of the Guaranteed Issue Amount (GIA). The form is available from your employer/benefits administrator, or is available online at http://www.mutualofomaha.com/eoi. The GIA is the lesser of 5 times your annual salary, or $150,000. For your spouse, the GIA is the lesser of 100% of the amount you enroll for, or $35,000. In no event shall your amount of insurance exceed 5 times your salary.

- You must elect coverage for yourself for your dependent(s) to be eligible.
- The benefit amount elected for your child(ren) cannot be more than 100% of your elected benefit amount.
- The benefit amount elected for your spouse cannot be more than 100% of your elected benefit amount.
- You must be age 70 or less for your spouse to be eligible for coverage. Spouse coverage terminates when you reach the age of 70.
- Your dependent child(ren) must be under age 26 to be eligible for insurance.

Beneficiary for Death Benefits (Right to change beneficiary is reserved to the insured.)

If naming more than one beneficiary, please attach a separate signed and dated sheet. Beneficiaries shall share benefits equally unless otherwise stated. Some states have laws regarding beneficiary designation. Please consult your employer/benefits administrator for additional information.

Primary Beneficiary Designation

Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)	SSN
Telephone:	Address of Beneficiary (Address, City, State, Zip):			

Secondary Beneficiary Designation

Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)	SSN
Telephone:	Address of Beneficiary (Address, City, State, Zip):			

Enrollment Information

Enrollment must occur within 31 days from the date the employee becomes eligible (or as otherwise stated in the applicable policy). If you are required to pay premiums for any coverage, the enrollment form **MUST** be signed and dated to authorize payroll deductions. The premium amounts indicated on this form are estimates, and are subject to change based on the final terms and conditions of the applicable policy as well as your age and/or salary on the effective date of the coverage.

Agreement and Signature

I represent that the information I have provided in this enrollment form is complete, true and accurate to the best of my knowledge. I understand that payment of premium does not guarantee eligibility for coverage. I understand and agree that I must satisfy all active work or active eligibility requirements that pertain to the policy to be eligible for coverage. I understand and agree that life insurance coverage for my eligible dependent(s) may be delayed if they are confined (at home, in a hospital, or in any other institution or facility) or disabled on the date insurance would otherwise begin, in accordance with the terms of the policy.

Should I apply for waived coverage in the future, I understand that evidence of insurability may be required, acceptable to the underwriting company, **at my own expense**. I understand that if coverage is applied for in the future, it must be during an enrollment period approved by the underwriting company or due to a life change event as defined or allowed by the applicable policy, and that a waiting period may apply.

By signing below, I acknowledge that I understand and agree to the above statements, and that I have read and understand the benefit summary or outline of coverage provided to me for each type of coverage. The above requirements will apply unless otherwise stated in the applicable policy, or unless prohibited by any applicable state or federal law.

SIGNATURE OF EMPLOYEE _____ **DATE** _____/_____/_____

Additional Information

Fraud Warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. *(Note: This fraud warning does not apply to residents of AL, AR, CA, CO, DC, FL, KS, KY, LA, ME, MD, NJ, NM, NY, OH, OR, PR, RI, TN, VT and VA. Please review the specific fraud warning for your state of residence if provided below, or view it online at www.mutualofomaha.com.)*

Vermont Fraud Warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claims containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may be committing a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

Position:			**Location:**					
Print Name:								
Health Selection: Blue Cross and Blue Shield					**Health Coverage Tier:**			
Platinum:		Gold:			Employee Only		Employee/Spouse	
Gold CDHP:		Silver CDHP:			Employee/Child(ren)		Family	
Declining Coverage:		**Yes**						
Dental Selection: Northeast Delta Dental					**Dental Coverage Tier:**			
Delta Dental PPO Plus Premier Network					Employee Only		Employee/Spouse	
					Employee/Child		Family	
Declining Coverage:		**Yes**						
Vision Insurance:					**Vision Coverage Tier:**			
VSP Insurance					Employee Only		Employee +Child/ren	
					Employee + One		Employee +Family	
Declining Coverage:		**Yes**						
Medical Spending Plan FSA:			**(Select Correct Box)**	**$ Amount**				
		I elect to Participate			$2,850.00 calendar year max			
		I elect ***NOT*** to Participate						
Dependent Care Spending Plan:			**(Select Correct Box)**	**$ Amount**				
		I elect to Participate			$5,000.00 calendar year max			
		I elect ***NOT*** to Participate						
HRA Participation Form Complete:		**Yes**						
Group Life Insurance :		**Yes/Enrolled**						
LTD Insurance :		**Yes/Enrolled**						
Voluntary Optional Life:		**Yes**		**No**	**Monthly Total:**		**$**	
Signature:	**Date:**	**Print Name:**						

Office Use Only:

Administration Teacher Para Educator Non-Con A Non-Con B Non-Con C Non-Con D AFSCME **Needs ProRated Time-ADS YES NO**

Timesheet: Yes No **Hourly Non-Exempt Salary Exempt 403b** **Reviewed by Human Resource Date:**