ENROLLMENT/CHANGE FORM ___ VERMONT **EMPLOYEE MEDICAL/DENTAL**

bŜǿ IꞪŜă: The 30-day ǿI·ꞪŭƴƎ ǈŜꞪƻŘ for coverage is currently ǿI·ꞪǾŜŘ. 5Ŝƴŭl·f ōŜƎꞪƴă ꞪÈ Ƴƻƴŭǩă I·ŦŭŜꞪ ŭǨŜ ŘI·ŭŜ ƻŦ ǨꞪŜ I·ƴŘ Ɜă ƴƻŭ ŜƫꞪƎꞪōƫŜ Ŧƻꞁ I· ǿI·ꞪŭƴƎ ǈŜꞪƻŘ ǿI·ꞪǾŜꞪ 9ƴꞪƻƫƫƳŜƴŭ Ƴdžăŭ ōŜ ǒƻƳǈƫŜŭŜŘ ǿꞪŭǨꞪƴ cл ŘI·èă ƻŦ ŘI·ŭŜ ƻŦ ǨꞪŜꞪ /ǨI·ƴƎŜăǀ 5ŜǈŜƴŘŜƴŭă ŎI·ƴ ōŜ ꞪŜƳƻǾŜŘ I·ŭ I·ƴè ŭꞪƳŜꞪ hdžŭăꞪŘŜ ƻŦ New Hire or hǈŜƴ 9ƴꞪƻƫƫƳŜƴŭ dependents ŎI·ƴ ōŜ I·ŘŘŜŘ ƻƴƫè ǿꞪŭǨꞪƴ cл ŘI·èă ƻŦ I· ǈdžI·ƫꞪŦèꞪƴƎ ŜǾŜƴŭ. Documentation must be supplied along with enrollment form (marriage/birth certificate, coverage term. letter, etc.)

> Complete using fillable form fields (do not handwrite).
> Save as a PDF.
> Email all completed forms to:
> **DHR.Benefits@vermont.gov**

❖ EMPLOYEE INFORMATION

Name: ______________________________ Employee ID: _______________

Date of Birth: ____________________

Home Phone: ____________________ Work Phone: _______________

❖ ACTION REQUEST

☐ New Hire ☐ Open Enrollment ☐ Add Dependent ☐ Remove Dependent ☐ Cancel Coverage

If Add/Remove, please give reason and effective date (i.e., Birth, Death, Marriage, Divorce, Coverage loss)

____

____

❖ STATUS

☐ Single ☐ Married ☐ Domestic Partner ☐ Widowed ☐ Divorced

If status has changed, please provide date of event __________

For a status change, include documentation of a qualifying life event within the past 60 days (E.g. Marriage License, Birth Certificate, Adoption Verification, Domestic Partner Application)

❖ BENEFITS

☐ I select the MEDICAL & DENTAL (complete #1, #2 & #3)

☐ I select DENTAL ONLY (complete #3)

#1. CHOOSE MEDICAL PLAN

☐ SelectCare POS
☐ TotalChoice

#2. CHOOSE COVERAGE

☐ Employee Only
☐ Two Person
☐ Family (Employee + 2 or more)

#3. DENTAL COVERAGE

☐ Employee Only
☐ Two Person
☐ Family (Employee +2 or more)

Coverage begins 6 months after date of hire, provided at no cost to employee

PLEASE PROVIDE ALL REQUESTED INFORMATION BELOW AND SIGN THE NEXT PAGE

❖ YOU & DEPENDENTS

Fill in your own information on the first line. Your dependents include your spouse, domestic partner, children under age 26. (Note: If adding a domestic partner email the notarized affidavit along with the enrollment form).

RELATIONSHIP CODES: Spouse = SP; Child = CH; Domestic Partner = DP

	Coverage Election: Medical	Coverage Election: Dental	Person Has Other Insurance
Employee Coverage	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

	Coverage Election: Medical	Coverage Election: Dental	Person Has Other Insurance	
Name: ________________	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	
Relationship: ____________	Date of Birth: __________		☐ Male ☐ Female	SSN: __________________

	Coverage Election: Medical	Coverage Election: Dental	Person Has Other Insurance	
Name: ________________	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	
Relationship: ____________	Date of Birth: __________		☐ Male ☐ Female	SSN: __________________

	Coverage Election Medical	Dental	Person Has Other Insurance		
Name: ________________	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N		
Relationship: ____________	Date of Birth: __________		☐ Male	☐ Female	SSN: __________________

	Coverage Election Medical	Dental	Person Has Other Insurance		
Name: ________________	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N		
Relationship: ____________	Date of Birth: __________		☐ Male	☐ Female	SSN: __________________

	Coverage Election Medical	Dental	Person Has Other Insurance		
Name: ________________	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N		
Relationship: ____________	Date of Birth: __________		☐ Male	☐ Female	SSN: __________________

FOR MORE DEPENDENTS USE SECOND FORM

PREMIUM REDUCTION PLAN

As a State of Vermont employee, you are entitled to pay your medical premium with pre-tax dollars. This is called a “Premium Reduction” plan. Below is a brief description of how the Premium Reduction plan works.

The Premium Reduction plan allows for your medical premiums to be deducted from your salary before any taxes are deducted. This is similar to the Deferred Compensation Plan and the Flexible Spending Account Plan. As a result, you pay less Federal, State and Social Security taxes. As with those accounts, by signing up for this plan, your contributions to Social Security will be slightly reduced since contributions are based on your income after deductions.

You must sign this form below to authorize the Payroll Division to deduct Medical premiums on a “pre-tax” basis. The Internal Revenue Service allows this benefit for active employees only. If you cease to be an active employee, you are no longer eligible.

YES, I WANT TO PARTICIPATE IN THE PREMIUM REDUCTION PLAN. MY SIGNATURE IS BELOW.

______________________ ______________________________________

Employee Number **Print Name (Last, First, Middle Initial)**

______________________ ______________________________________

Date **Signature**

I hereby request the above action and authorize the Department of Human Resources to withhold from my wages appropriate deduction(s), if any, toward the cost of coverage. I understand that any medical information that is pertinent and necessary for the payment of claims for me or my eligible dependents can be used in accordance with the privacy rules established by the Health Insurance Portability and Accountability Act. I certify that the above information is complete and correct and that all claims submitted will only be for eligible plan members.

EMPLOYEE SIGNATURE: ____ **DATE:** ________________________