ENROLLMENT/CHANGE FORM ___ VERMONT EMPLOYEE MEDICAL/DENTAL

[illegible] begins on the 31st day after the date of hire [illegible] New Hire or [illegible] dependents [illegible]. Documentation must be supplied along with enrollment form (marriage/birth certificate, coverage term. letter, etc.)

❖ **EMPLOYEE INFORMATION**

Return all completed forms to:
DHR.Benefits@vermont.gov
or
State of Vermont - Employee Benefits Unit
120 State Street - 5th Floor
Montpelier, VT 05620-2505
Fax: 802-828-5489

Name: ______________________________ Employee ID: ______________

Date of Birth: ____________________ SSN: ____________________

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 ☐ Dissolve Domestic Partnership or Civil Union

If status has changed, please provide date of event

YOU ARE REQUIRED TO SUBMIT PROOF OF QUALIFYING EVENT TO ADD DEPENDENTS
(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**

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

Fill in your own information on the first line. Your dependents include your spouse, civil union partner, qualified domestic partner, children under age 26, including children of your civil union or qualified domestic partner.

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

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

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

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

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

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

FOR MORE DEPENDENTS USE SECOND FORM

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:** _______________________

VERMONT

STATE OF VERMONT

DEPARTMENT OF HUMAN RESOURCES
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**

Send the completed form to:

Department of Human Resources
Employee Benefits Unit
120 State Street, 5th floor
Montpelier, VT 05620-2505
Fax: 802-828-5489

Or via email to: **dhr.benefits@vermont.gov**