



TOWN OF MADISON

CONNECTICUT 06443-2563

Rita C. Umile
*Manager of
 Human Resources,
 Office of the
 First Selectman*

FISCAL YEAR 2011-UPSEU COMMUNICATIONS & RECORDS STAFF

It is important to know that you can change your benefit plan and your level of coverage only during the annual open enrollment period. The only time outside of the open enrollment period that allows you to change your level of coverage for health benefits (within your selected plan) is when: you get married or divorced, your spouse or dependent dies, upon the birth or adoption of your child; if your spouse loses or obtains a job; or you or your spouse take an unpaid leave of absence. You may also change your coverage if you or your spouse changes from full-time to part-time employment or vice versa.

Flexible Benefits Plan

The Flexible Benefit Plan allows you to make your contribution toward your benefits with tax-free dollars. These dollars are not subject to FICA, Federal or State income taxes. I agree to have my gross salary reduced in accordance with Section 125 of the Internal Revenue Code. These monies will be used to cover my contribution toward the benefits listed below. This agreement will remain in effect until my employment terminates, a qualifying change occurs, my benefits change at the beginning of a new plan year, or my employer terminates, suspends or modifies the plan.

The rates listed below are for the 2010/2011 fiscal year. The employee cost share for Anthem Blue Care Plan is 10% and the employee cost share for Anthem Century Preferred Plan is 10%.

I elect to participate in Anthem Blue Care.	Please Circle Plan Desired
Cost of medical co-pay (every pay period):	
• Single:	\$32.26
• Two Person:	\$69.39
• Family Plan:	\$87.23
Dental co-pay (every pay period):	Please Circle Plan Desired
• Single:	0
• Two Person:	\$18.19
• Family Plan:	\$44.40

I elect to participate in Anthem Century Preferred Plan.	Please Circle Plan Desired
Cost of medical co-pay (every pay period):	
• Single:	\$31.58
• Two Person:	\$67.94
• Family Plan:	\$85.37
Dental co-pay (every pay period):	Please Circle Plan Desired
• Single:	\$0
• Two person:	\$18.19
• Family Plan:	\$44.40

PLEASE SIGN ATTACHED FORM AS AN AGREEMENT TO YOUR SALARY REDUCTION

I understand and agree to the above-chosen deductions for my benefits:

Employee Name (please print)

Employee Signature

Date

When making a change to your level of coverage, two forms must be completed—a “Benefits Reduction Agreement” and an “Anthem Enrollment Form.” These forms are available from Human Resources, as well as on the Town’s website. When completed, please return the forms to the Human Resources Office. If you have any questions, please stop by the HR Office, or call Rita Umile, Manager of Human Resources (203) 245-5603.