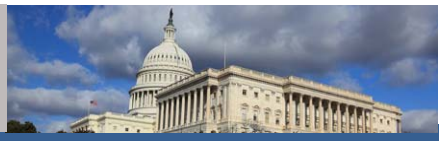


Health Care Reform: What Does it Mean for You?

In March 2010, President Obama signed into law the Patient Protection and Affordable Care Act (the Affordable Care Act). The health care reform law requires health plan sponsors to provide certain notices to employees during open enrollment.

- **Elimination of Lifetime and Annual Limits.** Group health plans may not establish lifetime limits on the dollar value of essential benefits. Group health plans may also not establish unreasonable annual limits. Common examples of those benefits deemed to be essential benefits include but are not limited to the following services;

    - Hospitalization
    - Maternity and Newborn Care
    - Mental Health and Substance Abuse Services
    - Laboratory Services
    - Prescription Drug Services
    - Preventive/Wellness Care
    - Emergency Services

  The health care reform law requires health insurance companies to remove lifetime dollar limits on benefits from all plans. This applies to medical and pharmacy benefits only; not dental or vision.

  The lifetime limit on the dollar value of benefits under the Anthem medical plan sponsored by the **Wethersfield Board of Education** no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. For more information, contact Human Resources at (860) 571-8112.

- **Patient Protections**. If you have a health emergency, you can go to any emergency room. You don't need to get approval from the plan first – even if the emergency room isn't in your plan's network. However, we do require you or your doctor to notify us of your visit after you go to the emergency room. Your plan covers both in-network and out-of-network emergency room services.

Benefit Description	Health Savings Acct (HSA) 002186-191		Century Preferred 002186-183 HBP 004	
	In Network	Out of Network	In Network	Out of Network
	You Pay	You Pay	You Pay	You Pay
		After Deductible		*After Deductible*
Preventive Care				
Well child care *	$0	20%	$0	20%
Periodic Routine Health Exams *	$0	20%	$0	20%
Routine Eye Exam	$0 every 12 months no vision rider	20%	$0 every 12 months with vision rider	20%
Hearing Screening	$0 once every two years	20%	$0 once every two years	20%
Routine OB/GYN visits Mammography *	$0 one exam per year	20%	$0 one exam per year	20%
Medical Care				
Primary/OB-GYN Office Visit	subject to ded & co-insur	20%	$20	20%
Specialist Consultations	subject to ded & co-insur	20%	$20	20%
Maternity Care	subject to ded & co-insur	20%	1st visit $20 then $0	20%
Laboratory	subject to ded & co-insur	20%	$0	20%
X-ray diagnostic tests	subject to ded & co-insur	20%	$0	20%
Allergy Services				
Office Visits	subject to ded & co-insur	20%	$20	20%
Injections & Testing	subject to ded & co-insur 80 visits in 3 years	20%	$0 80 visits in 3 years	20%
Hospital Care *Prior - Authorization Needed*				
Semi-private room	subject to ded & co-insur	20%	$200 per admit	20%
Maternity and Newborn Care	subject to ded & co-insur	20%	$200 per admit	20%
Skilled nursing facility	subject to ded & co-insur Up to 120 days per calendar year	20%	$200 per admit Up to 120 days per calendar year	20%
Rehabilitative services	subject to ded & co-insur Up to 60 days per calendar year	20%	$200 per admit Up to 60 days per calendar year	20%
Outpatient Surgery	subject to ded & co-insur in hospital or surgi-center	20%	$50 per admit in hospital or surgi-center	20%
Emergency Care				
Emergency Room	subject to ded & co-insur	20%	$75 waived if admitted	20%

Benefit Description	Health Savings Acct (HSA) 002186-191		Century Preferred 002186-183 HBP 004	
Urgent Care	subject to ded & co-insur Participating Centers Only	Not Covered	$75 Participating Centers Only	Not Covered
Walk-in Center	subject to ded & co-insur	20%	$20	20%
Ambulance	subject to ded & co-insur	$0	$0	$0
Other Health Care -				
Home Health Care	subject to ded & co-insur 200 visits per calendar year	20%	$0 200 visits per calendar year	20%
Outpatient Rehab Services includes P/T, O/T, S/T & Chiro	50 visits of combined benefits then paid at 80/20 costshare	20%	$0 50 visits of combined benefits	20%
Prosthetic Devices Ostomy Supplies	subject to ded & co-insur	20%	$0 Unlimited Max per year	20%
Durable Medical Equipment(DME)	subject to ded & co-insur	20%	$0 Unlimited Max per year	20%
Outpatient Cardiac Rehab therapy	subject to ded & co-insur Up to 36 visits per cardiac episode	20%	$20 Up to 36 visits per cardiac episode	20%
Infertility Services	subject to ded & co-insur Includes services and drugs	20%	$20 Includes services and drugs	20%
Mental Health/Substance Abuse Care				
Inpatient	subject to ded & co-insur	20%	$200	20%
Detoxification -inpatient	subject to ded & co-insur	20%	$200	20%
Outpatient	subject to ded & co-insur	20%	$20	20%
Additional Benefits				
Private Duty Nursing	subject to ded & co-insur	20%	20% Out of hospital only $15,000 max	20%
Prescription Drugs	Prescription drugs covered subject to deductible and co-insurance oral contraceptives included		co-pays of $10/$25/$40 with $2,000 max/yr. 2X co-pays for 90 day mail order supply oral contraceptives included	
***Preventive Care Exam Schedule**	$0	20%	$0	20%
Well Child	No Frequency or Age Restrictions Preventive Care Covered 100% - Not subject to deductible Out-of-Network serveice-subject to deductible and coinsurance		Birth to 1 Yr - 7 exams Years 1 through 4 - 7 exams Years 5 through 22 - exam every year	

Benefit Description	Health Savings Acct (HSA) 002186-191		Century Preferred 002186-183 HBP 004	
Preventive Exam (Adult)	No Frequency or Age Restrictions Preventive Care Covered 100% - Not subject to deductible Out-of-Network service-subject to deductible and coinsurance		Years 22 + - exam every year	
Mammography	No Frequency or Age Restrictions Preventive Care Covered 100% - Not subject to deductible Out-of-Network serveice-subject to deductible and coinsurance		Years 22 + - exam every year Additional exams when medically necessary	
Cost Share for Out of Network Services				
Deductible/Out of Pocket Max	In-Network	Out-of-Network	In-Network	Out-of-Network
Individual	1500/1500	1500/3000		400/$2000
2 or more members	3000/3000	3000/6000		1000/$5000
Lifetime Max			unlimited	unlimited
	Benefits to age 26		Benefits to age 26	
Annual cost: **Health Benefit**		**Employee Pays**		
Individual	**Total Premium**	**13% of Prem. + ded. $1125**	**Total Premium**	**Employee Pays 17% of premium**
2-Person		**13% of Prem. + ded. $2250**		
3 or More Members		**13% of Prem. + ded. $2250**		
Dental -Full Service	Benefits to age 19 regardless of student status		Benefits to age 19 regardless of student status	
Individual		**13% of Prem.**		**17% of Prem.**
2-Person		**Indiv % + full cost of dep**		**Indiv % + full cost of dep**
3 or More Members		**Indiv % + full cost of deps**		**Indiv % + full cost of deps**

Health Insurance Premium Cost Share

	Plan	Coverage	Total Cost Per Month	BOE Share Per Month	Employee Share Per Month	Annual Employee Cost
Nurse Staff	**Century Preferred**	Indiv	654.94	543.60	111.34	1336.08
	17% Employee	2-Person	1,338.13	1,110.65	227.48	2729.79
	Premium Cost Share	3 or More	1,721.82	1,429.11	292.71	3512.51
	Health Savings (HSA)	Indiv	618.75	538.31	80.44	965.25
	13% Employee	2-Person	1,237.38	1,076.52	160.86	1,930.31
	Premium Cost Share	3 or More	1,575.30	1,370.51	204.79	2,457.47
	Note: Employees enrolled in the **Health Savings Plan**, are responsible for meeting 50% of the $1500 individual or $3000 2 or more person deductible in addition to the employee premium cost share. The Board of Education will contribute the remaining 50% of the deductible.					
	Dental alone or with	Indiv	25.06	20.80	4.26	51.12
	Century Preferred	2-Person	68.39	20.80	47.59	571.08
	Plan. 17% Cost Share	3 or More	85.13	20.80	64.33	771.96
	Dental with	Indiv	25.06	21.80	3.26	39.09
	HSA Plan	2-Person	68.39	21.80	46.59	559.05
	13% Cost Share	3 or More	85.13	21.80	63.33	759.93

Questions & Answers regarding the Health Savings Account (HSA)

Question: **What is an HSA?**
Answer: An HSA is a high deductible health plan. Before non-preventive health care claims are paid by the insurance provider, a high deductible must first be met.

Question: **What is the benefit of an HSA?**
Answer: To help reduce the high cost of health insurance premiums, an HSA requires members to meet a high deductible to share in the cost of claims. To help offset the cost of the high deductible, the IRS allows members to fund their deductible pre-tax through payroll deduction. The pre-tax funds are placed in checking accounts established for each participating member to be used for qualified medical expenses. If unused, these pre-tax dollars continue to grow in the individual's account from year to year to be used for medical expenses at a later date. For instance, a healthy individual may utilize their health insurance benefits for preventive care visits only. As such, the health plan pays 100% of the cost and no deductible needs to be met. So the funds placed in the individual's account to pay the deductible continue to remain and grow in the account. The funds can be used for future medical expenses even after the employee retires. The concept is to save today for future needs.

Question: **By funding the deductible through pre-tax payroll deduction, will my social security benefits be affected?**
Answer: If you choose to fund the deductible through pre-tax deduction, social security taxes are not taken out of the wages used to fund the deductible, therefore, when an employee is eligible to collect social security benefits, it is possible the benefit may be affected.

Question: **How much is the total deductible?**
Answer: The total deductible for an individual is $1500 and $3000 for two or more persons

Question: **How much is the Board contributing?**
Answer: The Board is contributing $750 toward an individual deductible and $1500 toward a two or more person deductible.

Question: **How much of the deductible is the employee responsible for?**
Answer: This amount is known as the *Bridge Amount.* The employee is responsible for funding the balance remaining after the Board contribution.

Question: **Can the employee choose not to fund his or her share of the deductible?**
Answer: The employee does not have to place his or her share of the deductible into the HSA account. However, the employee is still responsible for his or her share of the deductible amount. For example, if a claim is filed and equals or exceeds $1500 or $3000 and the employee's account only contains the Board's contribution of $750 or $1500, then the employee would be responsible for the remaining balance.

Question: **Does the employee have to contribute his or her share through payroll deduction?**

Answer: No, the employee does not have to contribute to his or her share through payroll deduction. The employee may choose to contribute their share by sending money directly to their account. However, to be eligible to receive tax reduction benefits, contributions must be made through payroll deduction.

Question: **How does the employee notify the Board whether or not they wish payroll deduction?**

Answer: Employees choosing to enroll in the HSA plan must complete an *Anthem Enrollment/Membership Change Form* **and** the *Anthem Lumenos Health Savings Account Reduction Agreement.* The Reduction Agreement authorizes payroll deduction.

Question: **Can the employee contribute a greater amount to their HSA plan?**

Answer: Yes, per IRS Regulations the combined employee & employer contributions can equal up to $3050 for an individual account and $6150 for a two or more person account. Therefore, for the 2010 calendar year, the employee may contribute additional funds up to $1550 for an individual account and $3150 for a two or more person account.

Question: **Are there "catch-up" provisions?**

Answer: Yes, per IRS Regulations, persons age 55 and older and not enrolled in Medicare benefits may contribute up to an additional $1000 during the 2010 calendar year.

Question: **Do prescription claims apply toward the deductible?**

Answer: Yes, prescription claims will be applied toward the deductible.

Question: **Once the deductible is reached, are prescription claims paid at 80% or 100%?**

Answer: Once the deductible is met, prescription claims are paid at 100% as long as in-network providers are utilized.

Question: **Do dental claims apply toward the deductible?**

Answer: No, dental claims do not apply toward the deductible. However, dental costs are eligible medical expenses and monies held in the Health Savings Account can be utilized for payment of the claims.

Question: **Do eyeglass claims apply toward the deductible?**

Answer: No, eyeglass claims do not apply toward the deductible. However, eyeglass costs are eligible medical expenses and monies held in the Health Savings Account can be utilized for payment of the claims.

UNDERSTANDING YOUR CENTURY PREFERRED PRESCRIPTION DRUG FORMULARY

The 3-tier drug program incorporates different levels of co-payments.

$10.00 Generic Drugs
$25.00 Listed Brand-Name Drugs
$40.00 Non Listed Brand-Name Drugs
Mail Order prescriptions are subject to 2x the listed co-pays $20/$50/$80

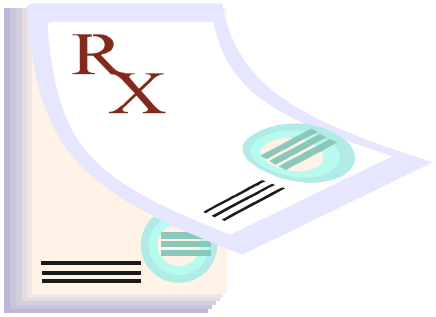
- For all **Generic** drugs, you will pay $10.00 for each 30-day supply purchased at a retail pharmacy.

- For all **Brand-Name Drugs**, listed and non listed, when a generic equivalent is available (unless your doctor indicates on your prescription **"Dispense as Written"**), you will be charged either the applicable $25 or $40 co-pay **as well as the difference in cost between the Generic and listed or non listed Brand name drug** for each 30-day supply purchased at a retail pharmacy. If your doctor indicates **"dispense as written"** on the prescription, you will be responsible only for the applicable $25 or $40 co-pay depending on your employee group.

- For **Mail Order** prescriptions, you will be responsible for 2 times the applicable co-pay for a 90 day supply. For example, you would pay $20.00 for a Generic prescription, $50.00 or $80.00 for an applicable listed or non listed Brand drug. If there is a Generic equivalent for the listed or non listed Brand name drug, you will also pay the difference in cost between the Generic and Brand drug for each 90 day supply purchased unless your doctor indicates "dispense as written" on the prescription.

- In addition to the co-pays, prescription rider benefits for members of the WSAA, WFT, NURSE, and NON-UNION ADMINISTRATOR employee groups have a maximum of $2,000 per calendar year. Once the $2,000 limit has been met, employees must meet the annual deductible and will be responsible for 20% of prescription costs through the remainder of the calendar year.

- Members of the CLERICAL, CUSTODIAL/MAINTENANCE, and NON BARGAINING UNIT- NON CERTIFIED employee groups have an unlimited maximum and are responsible for the co-pays only.



Talk to your doctor about using generic or brand name drugs listed on the formulary to help lower your co-payments.

Vist our website at www.anthem.com

VISION CARE PLAN

ANTHEM BLUE CROSS AND BLUE SHIELD'S VISION CARE RIDER OFFERS:

- Yearly eye examinations for vision corrections.
- Coverage for prescription lenses (single-vision, bifocals, trifocals), frames, and contact lenses with fitting, adjustment and aftercare for maintenance of comfort and efficiency.
- In-plan and out-of-plan coverage.

VISION EXAM COVERAGE:

Exam with dilation of pupils (cycloplegia) and post cycloplegic visit if required	Up to $50 per calendar year
Exam without cycloplegia	Up to $50 per calendar year

OPTICAL SERVICES:

Frames for prescription lenses	Up to $28 per calendar year
Single vision lenses	Up to $33.50 per calendar year
Bifocal lenses	Up to $52 per calendar year
Trifocal lenses	Up to $84 per calendar year
Contact lenses when used to correct visual acuity to 20/70 or when medically necessary	Up to $225 per calendar year
Contact lenses when used for any other reason, equivalent to amount payable for single vision	Up to $33.50 per calendar year

PRINCIPAL LIMITATIONS & EXCLUSIONS

Services, frames, and lenses required by the employer as a condition of employment. Sunglasses, tinted glasses or industrial glasses unless they are prescription lenses. Contact lenses for cosmetic, convenience or any purpose other than correction of visual acuity to 20/70 or medical necessity as determined by Anthem Blue Cross and Blue Shield, will be covered in an amount up to the single prescription lenses indemnity amount subject to the annual maximum.

FULL DENTAL PLAN

The Full Dental Plan covers diagnostic, preventive and restorative procedures necessary for adequate dental health.

COVERED SERVICES INCLUDE:

- Oral Examinations
- Periapical and bitewing x-rays
- Topical fluoride applications for members under age 19
- Prophylaxis, including cleaning, scaling and polishing
- Relining of dentures
- Repairs of broken removable dentures
- Palliative emergency treatment
- Routine fillings consisting of silver amalgam and tooth color materials; including stainless steel crowns (primary teeth)*
- Simple extractions **
- Endodontics-including pulpotomy, direct pulp capping and root canal therapy (excluding restoration)

* Payment for an inlay, onlay or crown will equal the amount payable for a three-surface amalgam filling when the member is not covered by Dental Amendatory Rider A.

** Payment for a surgical extraction or a hemisection with root removal will equal the amount payable for a simple extraction when the member is not covered by the Dental Amendatory Rider A.

ACCESSING BENEFITS:

Participating Dentists Benefits
When a member receives care from one of over 1,800 Participating Dentists, he or she simply presents his or her identification card showing dental coverage. The dentist bills us directly for all covered services.

For dental care provided by a Participating Dentist, we will pay the lesser of the dentist's usual charge or the Usual, Customary and Reasonable Charge as determined by us. The dentist accepts our reimbursement as full payment and may not bill the member for any additional charges.

Non-Participating Dentists Benefits
For covered dental services provided by a Non-Participating Dentist, in or out of Connecticut, we pay the lesser of the dentist's charge or the applicable allowance for the procedure, as determined by us. The member is responsible for any difference between the amount paid by us and the fee charged by the dentist.

This does not constitute your health plan or insurance policy. It is only a general description for the purposes of this Request for Proposal, of the Anthem Blue Cross Blue Shield Full Dental Plan. Refer to your Master Group Policy or Description of Benefits, on file with your employer, for a complete listing of benefits, maximums, exclusions and limitations.

Smart, simple savings

What is an FSA?

An FSA is a Flexible Spending Account that allows you to set aside money for eligible expenses on a pre-tax basis. There are two types of Flexible Spending Accounts available - a healthcare account and a dependent day care account.

A healthcare account reimburses you for out-of-pocket medical, dental, prescription or vision services, such as deductibles, co-pays, coinsurance and over-the-counter (OTC) items. Starting January 1, 2011, certain OTC medicines and drugs will be considered ineligible unless you have a written prescription from your doctor.

A dependent day care account reimburses you for expenses such as day care, before and after school programs, nursery school or preschool, summer day camp and even adult day care.

Quick Tip: View a listing of eligible expenses
Login to HealthHub.com > My HealthHub Resources > Planning Tools

An FSA is a smart way to save!

An FSA can help reduce your taxes and increase your take-home pay—giving you extra dollars for the things you really want.

With a salary of $20,000 and an annual contribution of $1,500 for healthcare...you could increase your take-home pay by $405!

With a salary of $40,000, an annual contribution of $1,750 for healthcare and $4,000 for dependent day care...you could increase your take-home pay by $1,553!

With a salary of $60,000, an annual contribution of $2,000 for healthcare and $4,500 for dependent day care...you could increase your take-home pay by $1,755!

Getting started is easy!

Start by estimating the amount that you will incur for eligible healthcare and/or dependent day care expenses during the plan year. Then review your expenses from the prior plan year and use our planning tools available at HealthHub.com to determine your contribution. The amount that will be deducted from your paycheck each pay period can be determined by dividing your annual contribution by the number of pay periods (e.g. 12, 24 or 26), in your plan year.

Quick Tip: Find out how much you can save
Login to HealthHub.com > My HealthHub Resources > Planning Tools

***My HealthHub Resources:* Education & Planning Tools**

- Savings calculator to help you estimate your healthcare & dependent day care expenses
- Digital library designed to help you understand FSAs
- Educational materials & forms to better assist you with your spending account(s)

What you need to know about FSAs

- You may only determine your contribution in an FSA during open enrollment or when you first become eligible.
- Once you establish your plan year contribution, you may only change it if you experience a change in status. This may include a change in one of the following conditions:
  - Legal marital status (marriage, divorce, legal separation, annulment or death of a spouse)
  - Number of tax dependents (birth, adoption or death)
  - Employment status that affects eligibility
  - Dependent satisfying or ceasing to satisfy coverage requirements (reaching limiting age, gain/loss of student status, marriage)

  * To apply for a change, you must complete a change-in-election form through your employer's Human Resources/Benefits department within 30 days of the date of the event.
- If your employer offers a "grace period", you will be allowed an additional 2 ½ months after the end of your plan year to use your FSA dollars. For example: if your plan year ends on December 31, your employer will allow expenses to be incurred through March 15.
- Any claims that were incurred during the plan year must be submitted for reimbursement by the end of your run out period. This date is established by your employer and is generally 90 or 120 days after the end of your plan year.
- Any amount left in your healthcare and/or dependent day care FSA at the end of the plan year will be forfeited.

HealthHub™
Powered by PayFlex®

Making the most of your FSA

Getting reimbursed

For quick and easy reimbursement, simply submit your healthcare and/or dependent day care expenses online at HealthHub.com. Your reimbursement will be deducted from your FSA account(s) and will be provided by check or direct deposit into your checking or savings account. If your employer offers the PayFlex Card™, you can use this to pay for eligible expenses and the amount will be automatically deducted from your FSA without having to submit a claim. If you paid out-of-pocket, remember to keep your receipt for your purchase to submit along with the claim form for reimbursement.

Quick Tip: Enroll in direct deposit
Login to HealthHub.com > Financial Center > Enroll in Direct Deposit

Reimbursement Methods

Online: www.HealthHub.com

Fax: 402.231.4310

Mail: PayFlex Systems USA, Inc.
PO Box 3039
Omaha, NE 68103-3039

Quick Tip: Download a claim form
Login to HealthHub.com > My HealthHub Resources > Administrative Forms

Remember to save your receipts & Explanation of Benefits

Stay informed with eNotify

If you are enrolled in eNotify, you will receive an email from enotify@payflex.com confirming that your claim has been processed.

Quick Tip: Sign up for eNotify to receive important e-mail notifications
Login to HealthHub.com > Settings > Change Email

Access account information you need on My Dashboard

Login to HealthHub.com to view a snapshot of your account:

- Account Balance
- News You Can Use
- Upcoming Claim Payments

Quick Tip: View your claim history and payments
Login to HealthHub.com > Financial Center > Select Account

Shop online with your FSA!

Access our Consumer Center to buy items such as glasses, contacts, and eligible over-the-counter items using your PayFlex Card™ (if offered by your employer) or any other major credit card. If an item is not identified as "FSA eligible" you will need to use a form of payment other than your PayFlex Card.
If using your own credit card, make sure to keep the receipt you receive from your purchase and submit along with a claim form for reimbursement.

Healthcare expense tips

- Healthcare expenses must be for services received after the effective date of your FSA election and during the plan year to which it applies.
- Each individual, allowed to use your healthcare FSA contribution generally includes your spouse, your child younger than age 19 OR, under age 24 and a full-time student OR any age and is permanently and totally disabled whom you are entitled to claim as dependent on your federal tax return. In addition, your child under the age of 27 may also be allowed to use your FSA dollars, if this feature is part of your plan.
- All expenses must be for services received, not for services to be provided in the future. In addition, the expenses cannot have been reimbursed and must not be reimbursable by insurance or any other source.
- You cannot claim the same expenses as a deduction on your annual income-tax return.

Dependent day care expense tips

- You and your spouse, if married must be actively working, seeking employment or a full-time student, in order to get reimbursed for your dependent day care expenses.
- Dependent day care expenses must be for services received after the effective date of your election and during the plan year to which it applies.
- Your expense(s) must be for a qualifying individual which includes a dependent younger than age 13; spouse or dependent who are physically or mentally incapable of self-care and for whom you are entitled to claim as a dependent on your federal tax return.
- Dependent day care services must be provided by an eligible dependent day care provider - a licensed day care facility that complies with applicable state and local laws.
- Dependent day care expenses must be for services received, not for services to be provided in the future.
- Dependent day care expenses can only be reimbursed up to the amount available in your account.
- The annual expense reimbursement may not exceed:
  - the lesser of your earned income;
  - if married; your spouse's earned income;
  - $5,000 ($2,500 if married, filing separate income tax returns)
- You must file Form 2441 annually with your individual tax return identifying all your dependent care providers.

Questions?

Contact Customer Service at 800.284.4885, 7am-7pm, Monday – Friday and Saturday 9am-2pm CT.

HealthHub™
Powered by PayFlex®

INSTRUCTIONS

Please print all information.

THANK YOU FOR CHOOSING OUR PLAN.

How to Fill Out This Form – Press Firmly – Please Use Ballpoint Pen

Please read these instructions before filling out the attached Enrollment and Membership Change Form. Here's what you need to fill out, so we can enroll you without delay.

For membership changes, complete:
Section 1. "Tell Us About You"
Section 3. "Change Membership"
In addition, when adding/cancelling eligible dependents, or changing a Primary Care Physician (PCP), complete:
Section 6. "List Family Members"

1. Tell Us About You

Please complete all information in this section.

2. New Membership

Please check the appropriate box. If you are enrolling as a COBRA or C.G.S. 38a-538 extension of coverage member, please indicate the date of the Qualifying Event, and also the Reason Code.

REASON CODE	QUALIFYING EVENT	REASON CODE	QUALIFYING EVENT
01	Divorce	04	Dependent child no longer eligible under terms of employer's contract
02	Termination of employment	05	Reduction in hours/no longer meet group eligibility requirements
03	Spouse of deceased employee		

3. Change Membership

Please check the appropriate box if you are changing membership. Please indicate the reason and date. Some examples include:

ADDRESS	MARRIED	DEPENDENT
PCP	LEGALLY SEPARATED	BIRTH
NAME	DIVORCED	ADOPTION

4. Your Membership Choices

A. Tell us the plan name in which you are enrolling. To do this, check the appropriate box next to your selection choice(s). If you choose "BlueCare", "Dental", or "other", please be sure to write the name of the plan as instructed by your Benefits Coordinator.
B. Please check individual, two person or family for each plan choice.

5. Where You Work

Please complete all information in this section.

6. List Members To Be Added/Cancelled

A. Please be sure to complete all information in this section including social security numbers, and the name(s) of recognized institution(s) for full time student dependent(s) age 19 or over.
B. Indicate last name if different.
C. If any dependent(s) listed are disabled, please circle that dependent, and attach the appropriate application which may be obtained from your Benefits Coordinator.

D. Special instructions for BlueCare. A Primary Care Physician (PCP) must be selected for each member. Each member may choose a different PCP. Specialists cannot be selected as PCPs. Please also write in the city or town where the PCP's office is located, and the PCP provider number, located in your Provider Directory.

An asterisk (*) next to a Physician's name in the provider listing means the physician can only be seen by a current patient. If you are a current patient and want that physician to be your PCP, please check the box next to the physician's name on the application.

E. If coverage is available through your employer's plan for domestic partnerships, please include the appropriate certification forms.

7. Tell Us About Your Other Insurance

Please be sure to note any other insurance information in this section.

8. Medicare/Medicaid

Please complete all information in this section if you or an enrolled member is covered by Medicare or Medicaid, or have applied for Medicare or Medicaid disability.

9. Employee Signature

Please sign and return the completed application to your employer's Benefits Coordinator. Save your copy of this form for your records until you receive your identification card(s). A copy of this application is provided to you as part of your Subscriber Agreement or health benefit plan document as applicable and is incorporated by reference therein.

Anthem

Enrollment and Membership Change Form

1. Tell Us About You

Current Anthem BCBS Contract Number, if any

Last Name | First Name | M.I.

Home Address: Number and Street or P.O. Box | Apt. #

City | State | Zip Code

Home Telephone ( )

Work Telephone ( )

MARITAL STATUS ☐ Single ☐ Married ☐ Legally Separated ☐ Separated ☐ Widowed ☐ Divorced

2. New Membership

☐ NEW HIRE
☐ OPEN ENROLLMENT
☐ COBRA/C.G.S. 38a-538
DATE OF QUALIFYING EVENT MM / DD / YR
REASON _____ SEE INSTRUCTION SHEET
☐ NEW GROUP (ORIG ENROLLMENT)

3. Change Membership

CHANGE:
☐ ADDRESS
☐ NAME
INDICATE FORMER NAME
☐ OTHER
REASON
DATE MM / DD / YR

To Be Completed By Employer

Requested Effective Date MM / DD / YR

Firm Division No.

Health Benefit Plan

For Office Use Only

4. Your Membership Choices

	Individual	Two Person	Family
☐ BLUECARE PLAN NAME	☐	☐	☐
☐ CENTURY PREFERRED/PPO	☐	☐	☐
☐ DENTAL PLAN NAME	☐	☐	☐
☐ HMO--NEW ENGLAND	☐	☐	☐
☐ Lumenos H.S.A.*	☐	☐	☐
☐ Lumenos H.R.A.	☐	☐	☐
☐ Lumenos H.I.A.	☐	☐	☐
☐ Lumenos H.I.A. Plus	☐	☐	☐
☐ OTHER PLAN NAME	☐	☐	☐

Anthem will facilitate the opening of a Health Savings Account in your name, if directed by your Employer.

Are you or any other eligible dependent listed on this form currently confined to a hospital or other healthcare facility, totally disabled or physically impaired? ☐ YES ☐ NO

5. Where You Work

COMPANY NAME

ARE YOU ACTIVELY AT WORK? ☐ YES ☐ NO / (IF NO) REASON ☐ SICK ☐ INJURED ☐ OTHER

ARE YOU CURRENTLY CLAIMING WORKERS' COMP. MEDICAL BENEFITS? ☐ YES ☐ NO

DO YOU WORK 30 OR MORE HOURS PER WEEK? ☐ YES ☐ NO

DATE OF FULL TIME HIRE	DATE OF PART TIME HIRE	DATE OF REHIRE
MM / DD / YR	MM / DD / YR	MM / DD / YR

6. List Members To Be Added/Cancelled

SEX	NAME (FIRST/MIDDLE/LAST NAME)	Add	Cancel	Social Security Number	Date of Birth (MM/DD/YYYY)	Full Time Student Age 19 or Over (Circle Yes or No)	BELOW PLEASE INDICATE NAME OF RECOGNIZED INSTITUTION FOR FULL TIME STUDENTS	Primary Care Physician (PCP) Name (Refer to Provider Directory or www.anthem.com) *Check √ the box if you currently use this physician.*
☐ M ☐ F	Self				/ /			Name PCP Provider No. ☐ City
☐ M ☐ F	Spouse				/ /			Name PCP Provider No. ☐ City
DEPENDENTS: Children over 19 may be eligible if disabled, or unmarried full-time students. Please circle disabled dependent.								
☐ M ☐ F	Dependent				/ /	Y N		Name PCP Provider No. ☐ City
☐ M ☐ F	Dependent				/ /	Y N		Name PCP Provider No. ☐ City
☐ M ☐ F	Dependent				/ /	Y N		Name PCP Provider No. ☐ City

7. Tell Us About Your Other Insurance

Do you or any other member of your family have any other medical, dental, or Anthem BCBS coverage? ☐ YES ☐ NO

If yes, please fill in the information below. ☐ Self ☐ Spouse ☐ Children

Name of Other Insurance Company	Name of Subscriber (Policyholder)	Policy or ID No.	Reason For Termination	First and Last Date of Coverage

8. Medicare/Medicaid

Do you or any covered member have Medicare/Medicaid coverage? ☐ YES ☐ NO

Have you or any covered member applied for Medicare/Medicaid disability? ☐ YES ☐ NO

Name (Self)	Are you actively at work?	Retirement Date	Name (Dependent)	Is this person actively at work?	Retirement Date
	☐ YES ☐ NO	MM / DD / YR		☐ YES ☐ NO	MM / DD / YR

Medicare No.	Medicare A (Hospital) Effective Dates	Medicare B (Medical)	Medicare No.	Medicare A (Hospital) Effective Dates	Medicare B (Medical)
	MM / DD / YR	MM / DD / YR		MM / DD / YR	MM / DD / YR

I understand that false and/or incomplete responses or statements may result in rescission of coverage and/or non-payment of claims for myself or my eligible dependents. I understand a copy of this application is provided to me as part of my Subscriber Agreement or health benefit plan document as applicable and is incorporated by reference therein. I certify that my statements in this form are true and complete to the best of my knowledge and belief.

9. Employee Signature

Date MM / DD / YR

COPY 1 - ANTHEM BCBS

The definitions listed below are for informational purposes only. For additional information, please refer to your Master Group Policy, Subscriber Agreement, or the Evidence of Coverage.

DEFINITIONS

ELIGIBLE EMPLOYEE: An Eligible Employee is defined as a full-time employee of the employer. In order to qualify as a full-time employee, the employee must be actively at work and working at least 30 hours per week on a regularly scheduled basis unless a higher number of hours per week is required by the employer. Temporary employees and seasonal employees are not eligible for coverage.

ELIGIBLE DEPENDENTS: a. An Eligible Employee's spouse under a legally valid existing marriage,
b. An unmarried, dependent child of an Eligible Employee, to age 19, or an unmarried dependent child between the ages of 19 and 23 who is a full-time student at a recognized college, university or trade school. Child includes a natural child, a legally adopted child or a child legally placed for adoption, a step-child who lives with the employee, a child supported by the employee pursuant to a valid court order, or a child for whom the employee is legal guardian.

EXCEPTION FOR NEWBORN: Newborn children are automatically entitled to coverage for the first 31 days following birth. If no additional premium is due Anthem BCBS, a completed Enrollment and Membership Change Form must be submitted to Anthem BCBS within a reasonable amount of time following birth in order to continue coverage without interruption.
If additional premium is required, a completed Enrollment and Membership Change Form must be submitted to Anthem BCBS within 31 days following birth in order for coverage to be continued without interruption.

LATE ENROLLEE: An Eligible Employee and/or dependent who requests insurance more than 31 days after the employee's earliest opportunity to enroll for coverage under any plan sponsored by the Employer may be considered a late enrollee. A Late Enrollee will be subject to a 12 month pre-existing condition waiting period for indemnity/PPO plans, or a 3 month affiliation period for HMO plans. Late Enrollees who are eligible for coverage will not be denied coverage, and completion of a statement of health form may be required.

An Eligible Employee and/or dependent will not be considered a Late Enrollee, if a request for coverage is made and all of the following conditions satisfied: (1) Coverage was not elected when the employee was first eligible under the group policy solely because another group health insurance plan provided coverage for the employee; and (2) Coverage is lost under that plan due to employment termination, death of a spouse, divorce, legal separation, loss of eligibility, COBRA benefit is exhausted, reduction in the number of work hours for employment, or the employer stops contributing to the health benefit plan; and (3) The employee applies for coverage under this contract within 31 days after loss of coverage under the other plan.

ACTIVELY AT WORK: The term Actively At Work means the employee must: work at the employer group's place of business or at such place(s) as normal business requires; and perform all the duties of the job as required of a full-time employee working 30 or more hours per week on a regularly scheduled basis.

WAITING PERIOD: Means a period of time that must pass before an employee or a dependent is eligible to enroll in the plan. The Anthem BCBS standard waiting period allows for new hires to be eligible to enroll for coverage following 30 days of continuous "actively at work employment." Generally new hires and their dependents who apply for coverage more than 31 days from the date first eligible will be considered a Late Enrollee.

EFFECTIVE DATES: New hires and their dependents will be effective the first of the month following completion of the waiting period. Effective dates for new hires may be deferred if all required information is not received, or is incomplete.

***PRE-EXISTING CONDITION:** (Required for Small Employer Groups 1-50) The term Pre-Existing Condition means a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, care, or treatment was recommended or received within the Pre-Existing Condition Period as specified in the Schedule of Benefits.

***PRE-EXISTING CONDITION PERIOD:** A period of time immediately prior to the effective date of coverage.

AFFILIATION PERIOD: Means a period of time that must expire before health coverage provided by an HMO becomes effective and during which the HMO is not required to provide benefits. No premium shall be collected for such period.

BENEFITS EXCLUSION PERIOD: A period of time during which no benefits will be provided for a pre-existing condition. Prior creditable coverage can reduce the length of a benefit exclusion period. We will request a certificate of prior creditable coverage from you regarding your previous health plan if necessary.

OPEN ENROLLMENT PERIOD: The term open enrollment means the period of time during which an employer group allows employees to select group health coverage.

*These provisions are not applicable to HMO products.

Health/Dependent Care Flexible Spending Accounts-FSA

Plan Year 7/1/2011 - 6/30/2012

Employer Use Only:
Re-enrollment __ New __ Change __
Effective Date _____
1st Deduction Date _____
Payroll Mode W B S M Q
Division Code _____

I. Personal Information (Please print clearly and provide complete and accurate information.)

Your Employer: Wethersfield Board of Education

Member Number (i.e. SSN) _____

Your Name _____
(Last) (First) (MI)

Address_____ **City** _____ **State** _____ **Zip** _____

☐ *Check if this address is new within last year.* **Date of Birth** _____/_____/_____ **Hire Date** _____/_____/_____

II. IRS Code Section 125 Information

a. ☐ Yes, I wish to participate in the **IRS CODE SECTION 125** - group health insurance premium cost share to be paid with before-tax dollars

Flexible Spending Account Election

b. ☐ Yes, I wish to participate in the flexible spending account plan and authorize payroll reduction from my salary on a pre-tax basis in the amount(s) indicated below, and continuing until this election is amended or terminated or until the Plan Year ends. Employer-sponsored benefit coverage contributions are automatically reduced from my compensation on a pre-tax basis.

FLEXIBLE SPENDING ACCOUNT BENEFIT CHOICES	PLAN YEAR AMOUNT
Health Care Reimbursement Account - Plan Year Maximum is $2,000	**$**_____•____
Dependent Day Care Reimbursement Account - Plan Year Maximum is $5,000 (If married, this amount is less than my spouse's earned income)	**$**_____•____

I understand that:

- This election can only be changed or revoked during the Plan Year if I have a change in status as defined in the Plan or if I am no longer eligible to participate. The new election must be consistent with my change in status, must be applied for within 30 days of the change, and is subject to final approval by my employer.
- This election will be automatically changed or cancelled, if necessary, to comply with provisions of the Internal Revenue Code or if required employer-sponsored benefit contributions increase or decrease.
- The maximum exclusion under a Dependent Care Reimbursement Account for married individuals filing a joint return is $5,000 per calendar year. Married individuals filing separately will get a lower exclusion ($2,500 per calendar year). IRS Form 2441 must be filed with my personal income tax return.
- Any amounts remaining in my reimbursement accounts at the end of the Plan Year will be forfeited.
- Salary contributed into one reimbursement account cannot be transferred and used for expenses in any other account.
- A new Enrollment Form must be completed each Plan Year. If I do not complete and return an Enrollment Form during Open Enrollment, I forfeit the opportunity to participate in the Benefit Choices outlined above.
- Social Security and Medicare taxes are not being withheld on the amount of my salary reduction under this election.
- The amount of salary reductions may not be claimed on my or my spouse's income tax returns.
- If my employment terminates, only medical expenses incurred through my period of coverage as defined in the Plan can be considered for reimbursement.
- I understand all claims submitted for reimbursement are subject to substantiation requirements and I am required to, and agree to, provide documentation as requested.

III. Pre-Authorization for Direct Deposit of Flexible Spending Reimbursement Checks (If you are already enrolled in direct deposit with PayFlex or do not wish direct deposit for Flexible Spending Reimbursement checks, ignore this section.)

☐ I authorize PayFlex Systems USA, Inc. to initiate a credit and/or debit entry to my account for my PayFlex reimbursements. This agreement is to remain in full effect until written notification is supplied by me to PayFlex terminating this agreement. A "VOIDED" CHECK MUST ACCOMPANY DIRECT DEPOSIT APPLICATION

Employee Signature _____ Date _____

Rev.4/27/2011

Wethersfield Public Schools
127 Hartford Avenue
Wethersfield, CT 06109

Anthem Lumenos Health Savings Account

Plan Year: 7/1/2011-6/30/2012

An Anthem Lumenos Health Savings Account has been established to allow eligible employees to contribute money pre-tax to an account, which is used to pay for qualified medical expenses until the deductible of a *High Deductible Health Plan* is reached. The Mellon Bank Group has been contracted by Anthem Blue Cross to set up an account for each participating member.

In addition to the premium cost share for participation in the plan, the deductible to be met for the 2011-2012 plan year is $1,500 for an individual plan and $3,000 for two or more covered persons. To help offset the cost of the high deductible for the plan year 2011-2012, the Board of Education will fund a portion of the deductible by depositing an amount based on bargaining unit membership into a member's Mellon Bank account as follows:

- **WFT** Teachers bargaining group: $750 for individual plan or $1500 for two or more person plan
- **WSAA** Administrative bargaining group: $750 for individual plan or $1500 for two or more person plan
- **CSEA** Cler/Secty/Para bargaining group: $750 for individual plan or $1500 for two or more person plan
- **CSEA** Cust/Maint bargaining group: $750 for individual plan or $1500 for two or more person plan
- **Non-Certified** Non Affliated Staff: $750 for individual plan or $1500 for two or more person plan

The portion of the deductible not funded by the Board of Education is called the *Bridge Amount.* Participating employees are responsible for the *Bridge Amount,* $750 if the plan is for individual coverage, or $1500 if the plan is for two or more. Employee's have the option of funding this amount pre-tax through payroll deduction or post-tax by sending a check to the address printed on the employee's Mellon Bank HSA account.

Per IRS Regulations employees may also contribute to their HSA account an additional amount above the bridge amount up to $1500 for an individual plan or $2950 for a 2 or more person plan pre-tax through payroll deduction. The total amount of Board and Employee deposits into an HSA account for the 2011-12 calendar year cannot exceed $3050 for an individual plan or $6150 for a two or more person plan. Employee's age 55 or older and not enrolled in Medicare may contribute up to an additional $1000 under the "catch-up" provision.

If you have opted to enroll in the Anthem Lumenos High Deductible Health Insurance Plan please complete the attached **Anthem Lumenos Health Savings Account Reduction Agreement**, sign and return the document to the Human Resource Department, Wethersfield Public Schools, 127 Hartford Ave., Wethersfield, CT 06109 by no later than **Tuesday, May 31, 2011**.

Anthem Lumenos Health Savings Account Reduction Agreement

Plan Year: 7/1/2011-6/30/2012

Employee Information

1. Employee Name	**2. Employee Address** **Street** _____ **City**_____**ST**____**Zip**_____	**3. Social Security Number**
4. Would you like to fund **ALL OR PART** of your "Bridge Amount" pre-tax through payroll deduction: Yes _____ No _____ If yes, Please complete Box 5 If no, Please complete Box 6	**5. My total "Bridge Amount" is $_____** ------- I would like to fund **ALL** of my Bridge Amount through 20 payroll deductions between September and June. _____ I would like to fund my Bridge Amount in one lump sum on the first payroll deduction withholding HSA funds. _____ **6. My total "Bridge Amount" is $_____** _____ I will fund my Bridge Amount by sending a check directly to my Mellon Bank account **or by paying for services out-of-pocket and understand I will not receive a pre-tax benefit**	**7. I would like to contribute an additional $_____ above my bridge amount to my Mellon Bank account pre-tax through payroll deduction.** ***check all that apply below*** _____ I am enrolled in an individual plan and can contribute to a maximum of $1550 above my bridge amount. _____ I am enrolled in a 2 or more person plan and can contribute to a maximum of $3150 above my bridge amount. _____ I am age 55 or older and can contribute up to a maximum of $1000 above the regular limits under the "catch-up" provision.

Participation Agreement & Salary Reduction Authorization

I acknowledge that I received and read the Health Savings Account Information and that I understand the benefits, rights, and obligations available to me under the plan, and that any deductions made through payroll will be on a pre-tax basis.

_____ _____

Employee Signature Date

For Office Use Only

Effective Date: _____	Pay Periods Remaining: _____	Payroll Deduction: $ _____

LIFE INSURANCE ENROLLMENT FORM

SECTION 1: EMPLOYER INFORMATION

Employer	Policy Number	Workplace Location
Wethersfield Public Schools	**Life**: FLX 961722	**127 Hartford Avenue, Wethersfield, CT 06109**

SECTION 2: EMPLOYEE INFORMATION

Last Name	First Name	MI	☐ Male ☐ Female

Social Security Number	Date of Birth	Date Employed	Occupation

SECTION 3: BENEFIT CHOICES

I elect the following options as: ☐ **New Enrollment**
☐ **Enrollment Change (option available during open enrollment or due to life change only)**
☐ **Beneficiary Change (complete sections 2, 4 & 5 only)**

☐ **Term Life** (***Board paid benefit****, amount determined by bargaining unit agreement under which individual is employed*)

☐ **Additional Life (***Eligibility to enroll is determined by bargaining unit agreement under which individual is employed, employee cost per month is $2.00 for each 10,000 increment,* r*equest amount in $10,000 increments to a maximum of $30,000)*: Requested Amount $_____

BENEFICIARY INSTRUCTIONS

Provide the Beneficiary's complete name, address, Social Security number and the relationship to the insured. Examples:

A. One Primary Beneficiary	Dorothy Q. Smith, wife (not Mrs. John Smith)
B. Two Primary Beneficiaries	Peter Smith, father, and Anna Smith, mother, equally, or the survivor
C. Primary Beneficiaries in unequal shares	Peter Smith, father 75%, and Ann Smith, mother 25%, or the survivor
D. Trustee	Dorothy Q. Smith, trustee under trust agreement dated:
E. Your estate	My estate

Note: Any Contingent Beneficiary named will be paid the death benefit if the Primary Beneficiary is not living at the time of your death or dies within 15 days after the date of your death. If you do not name a Beneficiary, or if you are not survived by a Beneficiary, all death benefits will be paid to your estate.

Do you know that if death occurs and you have named a minor (a person not of legal age) or your estate as Beneficiary, it may be necessary to have a guardian or a legal representative appointed before any death benefit can be paid? This could mean legal expenses for the Beneficiary and a possible delay in the payment of the insurance. Please take this into consideration when naming your Beneficiary.

SECTION 4: BENEFICIARY INFORMATION

Name	Address	Social Security Number	Relationship
Primary			
Contingent(s)			

SECTION 5: EMPLOYEE AUTHORIZATION

I agree with the terms and conditions of my benefit elections and authorize deductions from my wages if required to cover my contribution if any toward the cost of my insurance.

Signature _____ Date: _____

For Office Use Only

Class:	Benefit Effective Date:	Basic earnings (from this Employer): $

WETHERSFIELD PUBLIC SCHOOLS
127 Hartford Avenue
WETHERSFIELD, CONNECTICUT 06109

TO: Full-Time Employees Eligible for Benefits

RE: Voluntary Long-Term Disability Benefit

Voluntary long-term disability is a benefit that will pay you a portion of your salary if you are unable to work due to an injury or sickness that kept you out of work for ninety (90) days or more. The benefit is sixty percent (60%) of your monthly pay to a maximum of $4,000 per month.

If you are a new employee being offered the benefit for the first time, you need only complete the *LTD Insurance Enrollment Form*. The enrollment form must be returned to the Human Resource Department for processing within two weeks of your hire date.

If you are a current employee who chose not to enroll in the benefit when the plan was first introduced or at the time of hire, you may apply for coverage during the open enrollment period. Current employees wishing to participate in the program must complete the *LTD Insurance Enrollment Form* **and** the *Evidence of Insurability Form.* Eligibility to participate is subject to review by CIGNA Group Insurance. Upon review of both documents, CIGNA will either approve or deny eligibility to enroll in the Long Term Disability program.

Completed forms must be returned to the Human Resource Department for processing within two weeks of hire or by the end of the open enrollment period. Please note; if you are a current employee, coverage will not take effect until the day CIGNA approves you in writing for the coverage.

If you have any questions regarding the Voluntary Long-Term Disability plan, please contact the Human Resource Department at (860) 571-8112.

Thank you.

LTD Insurance Enrollment Form

Office Use Only
Benefit Eff Date: _____
Cancellation Eff Date _____
Basic Earnings _____

Section 1: Employer Information

Employer	Policy Number	Workplace Address
Wethersfield Public Schools	**LTD**: LK 961345 **VOL LTD:** VDT-960181	**127 Hartford Avenue, Wethersfield, CT 06109**

Section 2: Employee Information

Last Name	First Name	MI	☐ Male ☐ Female

Social Security Number	Date of Birth	Date Employed	Occupation

Section 3: Benefit Choices

I elect the following options as: ☐ **New Enrollment** ☐ **Open Enrollment**
☐ **Policy Cancellation** *(option available during open enrollment or due to life change only)*

☐ **Long Term Disability** (*Available to Administrative Staff only*)

☐ **Voluntary Long Term Disability** (*Available to all employees eligible for insurance benefits at employee's expense, use table below to calculate cost per month*)

Section 5: Employee Authorization

I agree with the terms and conditions of my benefit elections and authorize deductions from my wages if required to cover my contribution if any toward the cost of my insurance.

Signature _____ Date: _____

To Calculate Your Cost Per Month for Voluntary Long Term Disability Benefits:

Step 1: Determine your annual salary. If you are an hourly employee you must first calculate your "annual salary" by entering the information below. (If you are a salaried employee (i.e. teacher) skip to step 2)

Hourly Employee Calculation:	
# of hours you work each day	
Hourly rate of pay	**$**
# of days worked per year	
Annual Salary*	**$**
*Multiply # hrs per day x hr rate x # days per year to = annual salary	

Hourly Employee Work Year Schedule	
Days/Yr	**Position Description**
260	12-Month Employees
211	11-Month Employees - Secretaries to Instructional Supervisors *(216 days if hired prior to 8/18/08)*
200	10-Month Employees - Secretaries, Clerks, Media Aides, A-V Tech *(205 days if hired prior to 8/18/08)*
190	10-Month Employees - Paraprofessionals, Computer Lab Assistants *(195 days if hired prior to 8/18/08)*

1)	Enter Annual Salary	$	(Use base salary only, do not include stipends or extra pay.)
2)	Divide annual salary by 12 mos.	$	Cannot exceed $6,666/month - if amount shown is greater, enter the lesser amount.
3)	Enter Rate for your Age Group **(See Rate Table)**	**x**	Multiply line 2 x line 3 = Monthly Prem.
	Monthly Premium =	$	

Note: If you are a 10-month employee, your benefit continues throughout the summer, therefore, your monthly pay is based on a 12-month period.

Step 2: Calculate the monthly cost of your *voluntary long-term disability* benefit by using the rate table below.

Rate Table			
Age	**Rate**	**Age**	**Rate**
Under 24	.00115	55-59	.00690
25-29	.00105	60-64	.00590
30-34	.00193	65-69	.00425
35-39	.00227	70-74	.00264
40-44	.00356	75-79	.00295
45-49	.00450	80-84	.00197
50-54	.00620	85 & over	.00189

EVIDENCE OF INSURABILITY FORM FOR DISABILITY INSURANCE

Life Insurance Company of North America (LINA)
a CIGNA Company (herein called the Insurance Company)
For info and customer service call 1-800-759-0101.
- *The applicant must sign and date this form.*
- *This form cannot be considered unless received within 30 days of the date it is dated.*

CIGNA Group Insurance
Life · Accident · Disability

Important: *Please enter all dates in mm/dd/yyyy format.*

EMPLOYER USE (MANDATORY DATA NEEDED): In order for the insurance company to process this form, the employer must complete this information.

EMPLOYER Town of Wethersfield (Board of Education) **POLICY #** VDT-960181 **CLASS** _____

OCCUPATION _____ **LOCATION/PAYCODE** _____ **DATE OF HIRE** _____

ANNUAL SALARY _____ **AMOUNT TO BE UNDERWRITTEN** _____ **VERIFIED** _____ **DATE** _____

REASON FOR REQUEST: ❑ **LATE ENTRANT** ❑ **LIFE STATUS CHANGE** ❑ **ONGOING ENROLLMENT EVENT**

Please print (preferably in black ink).

EMPLOYEE INFORMATION

Name (First) _____ (Last) _____ (Middle Initial) _____

Social Security Number _____ Employee ID Number _____ Sex: ❑ M ❑ F

Address _____ Apt. # _____ City _____ State _____ Zip _____

Day Phone _____ Evening Phone _____ Date of Birth (Mo/Day/Year) _____

ACCEPTANCE / DECLINATION

In order to confirm your election, you must provide a signature for Life Insurance Company of North America.

Signature _____ Date _____ (Mo/Day/Year)

IMPORTANT
Please complete each section that follows.
Read the Agreements and Authorization. Sign and date the form in the space provided.

Complete the employee info in this section if you (i.e., the Employee) are applying for Disability Insurance more than 31 days after you are eligible.

Height and Weight Information

Employee	Height	ft	in	Weight	lbs

PHYSICIAN SECTION

Employee Physician

Name _____ Phone No. _____

Street Address _____ City _____ State _____ Zip _____

Please indicate your answers for each question by checking the Yes or No box for the question.

SECTION A

Within the last 5 years has the proposed insured been:
- diagnosed with any of the conditions shown in items A through O below,
- told by a medical professional he/she has or may have any of the conditions shown below,
- or been treated by a medical professional for any of the conditions shown in items A through O below?

		Employee Yes	Employee No
A.	High blood pressure, heart attack, chest pain or Angina, a heart murmur, poor circulation or any other condition affecting the heart or circulatory system?	❑	❑
B.	Diabetes, glandular condition, Hepatitis, or any condition affecting the esophagus, stomach, intestines, liver or pancreas	❑	❑
C.	Asthma, Chronic Bronchitis, Emphysema, or any other condition affecting the lungs or respiratory tract?	❑	❑
D.	Any condition affecting the kidneys, urinary tract, prostate gland or reproductive system?	❑	❑
E.	AIDS or any other condition affecting the immune system or lymph nodes?	❑	❑
F.	Stroke, Transient Ischemic Attack (TIA), Alzheimer's disease, paralysis, Epilepsy, fainting, seizures, headaches, or other condition affecting the nervous system?	❑	❑
G.	Anemia or any other condition affecting the blood, Lupus, Arthritis, deformity or loss of limb?	❑	❑
H.	Anxiety, Depression, Bipolar Disorder, or any other mental disorder or condition?	❑	❑
I.	Cancer, Tumor, Leukemia, Hodgkin's Disease, Polyps or Mole?	❑	❑
J.	Alcohol or drug abuse or dependency?	❑	❑
K.	Any condition affecting hearing or vision, including any loss of sight or hearing, or dizziness or Vertigo?	❑	❑
L.	Carpal Tunnel Syndrome; neck, back, knee or joint condition, strain, sprain or other type of injury?	❑	❑
M.	Any bone, joint, or muscle condition persisting for, or having been treated for, 6 months or longer?	❑	❑
N.	Fibromyalgia, chronic pain, Chronic Fatigue, Irritable Bowel Syndrome (IBS), Multiple Sclerosis, or Temporomandibular Joint (TMJ) Disease?	❑	❑
O.	Received any form of physical therapy; been seen by a chiropractor or other non-MD medical practitioner or therapist for any reason?	❑	❑

Fold and staple to conceal health questions. Return to your employer. Be sure to make a copy for your own records.

Name _____ Social Security # _____

Please indicate your answers for each question by checking the Yes or No box for the question.

SECTION B

Within the last 5 years has the proposed insured:	Employee Yes	Employee No
A. Had a Driving While Intoxicated (DWI), Driving Under the Influence (DUI) or Operating Under the Influence (OUI) conviction?	❑	❑
B. Smoked cigarettes:	❑	❑
1. For how many years has the proposed insured smoked?_____		
2. Approximately how many cigarettes are, or were, smoked on average per day?____		
3. If cigarette smoking has been discontinued, when (month and year) did the proposed insured quit smoking? Month_____ Year_____		
C. Used any controlled or illegal drug or other substance?	❑	❑
D. Been seen for, or been advised to have sought treatment for, observation and/or consultation for surgery, medical examination, and/or tests, such as blood, urine, X-rays, electrocardiograms, scans, biopsies, or any medical tests/exams not listed here or above, other than normal routine physical exams?	❑	❑
E. Used any medication prescribed by a physician or other medical practitioner, or used any form of alternative and complementary medical treatment or remedy, including herbs or acupuncture?	❑	❑
F. Been seen, sought treatment for, consulted, advised they had and/or received any medical advice from a health care practitioner for any disease, disorder and/or medical impairment not listed above?	❑	❑

Use the space below to explain "Yes" answers. If more space is needed, use a new page. Sign and date it. Attach it to this form.

Name of Employee	*Condition*	*Date Occurred*	*Duration/Treatment Received*	*Current Status*

Caution: *Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.*

✦✦✦ AGREEMENTS AND AUTHORIZATION ✦✦✦

To the best of my knowledge and belief all written, telephonic and electronic info I gave is true and complete. I understand that my insurance will not go into effect unless I am actively at work on the effective date. The conditions for the requested insurance to be effective are described in the policy and certificate. The approval of this request by the Insurance Company is one of those conditions. I understand and agree that:

(1) This request will be a part of the policy that provides the insurance.
(2) I may need to provide more medical info.
(3) I may need to take medical tests and report the results to the Insurance Company.
(4) I must report any change in my health that happens before the insurance is effective.
(5) Requested insurance will not be effective for a person if the person does not meet the underwriting requirements on the date insurance is to be effective.

Authorization. I permit any hospital, clinic, health care practitioner, pharmacy, benefit manager, employer, insurance company, the Medical Information Bureau (MIB) or any other person or organization having info about the health, medical history, physical or mental condition, diagnosis or treatment, employment or income, or motor vehicle driving record of me to disclose to the Insurance Company or its authorized agent, any such info, for the purpose of underwriting this application for insurance or administering any claim under any insurance which is approved. This authorization is valid for 30 months from the date below. I accept that a copy of this Authorization is as valid as the original.

I understand that I and/or my authorized agent have the right to receive a copy of this authorization upon request.

I understand that the info will be used to assess my request for insurance.

I may revoke this authorization at any time in writing. Any such revocation will not: (1) change any action taken in reliance on the Authorization; and (2) change the Insurance Company's right to use the Authorization for contest of a claim or policy in accordance with applicable law.

I understand that info provided pursuant to this authorization may be disclosed by the recipient and is no longer subject to the protections of the Health Insurance Portability and Accountability Act (HIPAA). (The Insurance Companies are subject to the Gramm-Leach-Bliley act and state privacy laws. They do not disclose protected information except as permitted by those laws.)

Pre-Existing Condition Limitation (applies to long-term disability insurance only): I understand if I become insured, I will not receive benefits for a Pre-existing Condition until I have been insured for 12 months for the Disability coverage. "Pre-existing Condition" means any Injury or Sickness for which the Employee incurred expenses, received medical treatment, care or services, including diagnostic measures, took prescribed drugs or medicines, or for which a reasonable person would have consulted a Physician within 3 months before his or her most recent effective date of insurance.

☛

Sign Here _____ *Employee's Signature* _____ *Month/Day/Year*

Notice: Personal information may be collected from persons other than those proposed for coverage. Information may be disclosed to third parties without your authorization as permitted by law. You have the right to access and correct all personal information collected. Additional information about the insurance company's privacy practices is available upon request.