

NORTH ATTLEBORO TOWN GOVERNMENT

BENEFITS CHECKLIST for plans beginning July 1, 2025, to June 30, 2026

Coverage to begin on the 1st of the month following date of hire.

***If a 3rd pay week occurs in a month, there will be no health insurance deduction for that week. (Bi-Weekly Deductions)**

BLUE CROSS BLUE SHIELD OF MASSACHUSETTS HEALTH INSURANCE

If you elect to participate in the Health Insurance Program, you **MUST** complete the Enrollment Change Form to be submitted to the Insurance Carrier. Coverage to begin on the 1st of the month following date of hire. **(Bi-Weekly Deductions)**

I am aware that I am responsible for paying the premium in full that is paid one month in advance of the effective date of coverage along with the bi-weekly premium.

PLAN TYPE:	INDIVIDUAL RATE	FAMILY RATE
_____(HMO) NETWORK BLUE NEW ENGLAND DEDUCTIBLE PLAN	\$127.19	\$333.40
_____(PPO) BLUE CARE ELECT DEDUCTIBLE PLAN	\$227.95	\$567.52
_____(HDHC) ACCESS BLUE NEW ENGLAND SAVER HIGH-DEDUCTIBLE PLAN	\$101.75	\$266.72

I currently have coverage with my previous employer which will end on _____

____ I am presently declining coverage

EYEMED VISION INSURANCE

If you elect to participate in the Vision Program, you **MUST** complete the Enrollment Change Form to be submitted to the Insurance Carrier. Coverage to begin on the 1st of the month following date of hire. **(Bi-Weekly Deductions)**

I am aware that I am responsible for paying the premium in full that is paid one month in advance of the effective date of coverage along with the bi-weekly premium.

PLAN TYPE:

____ I would like to enroll in an EMPLOYEE ONLY Plan (\$1.82)

____ I would like to enroll in an EMPLOYEE & SPOUSE Plan (\$3.10)

____ I would like to enroll in an EMPLOYEE PLUS ONE OR MORE CHILDREN (\$3.19)

____ I would like to enroll in a FAMILY (\$5.01)

I currently have coverage with my previous employer which will end on _____

____ I am presently declining coverage

100% EMPLOYEE PAID BENEFITS

ALTUS DENTAL INSURANCE PLAN

If you elect to participate in the Dental Insurance Plan you **MUST** complete the Enrollment Form to be submitted to the Insurance Carrier. Coverage to begin on the 1st of the month following date of hire. (Bi-Weekly Deductions)

I am aware that I am responsible for paying the premium in full that is paid one month in advance of the effective date of coverage along with the bi-weekly premium.

_____ I would like to enroll in an Individual Plan (\$18.04)

_____ I would like to enroll in a Family Plan (\$54.72)

I currently have coverage under my previous employer, which will end on _____

_____ I am presently declining coverage

\$1,500 Annual Maximum (in-network & out-of-network combined) ♦ \$1,000 Elective Orthodontic Lifetime Maximum at 50% (to age 19) ♦ Deductible—Individual \$50 / Family \$150 ◊ Maximum Lifetime Cap Unlimited ♦ Dependent Coverage: Dependent children covered under a family plan are covered under these benefits up until the end of the month that they turn age 26.

BOSTON MUTUAL BASIC & VOLUNTARY TERM LIFE INSURANCE

Deductions are made on the 1st pay of the month. If you elect to participate in the Life Insurance Program, you **MUST** complete the Enrollment Form to be submitted to the Insurance Carrier.

_____ I would like to enroll in the Basic Life Insurance Program (\$10,000 coverage at \$1.35 cost per month -> 25% Employee Cost) ■ **Total Monthly Premium: \$5.40** ■ **Town Monthly Cost (75%): \$4.05** ■ **Employee Monthly Cost (25%): \$1.35**

_____ I am presently declining coverage (If you elect to decline coverage you **MUST** sign off on the Refusal of Insurance Form)

_____ New Enhanced Term Life Insurance *(**MUST** be enrolled in the Basic Life Insurance Plan)

_____ I am presently declining coverage

Life/AD&D Rates ***SEE ISSUE AGE OPTION***

Amount of Insurance Employee \$ _____ Cost \$ _____

Dependent Life: Spouse \$ _____ Child (ren) \$ _____

(Employees **MUST** have coverage to insure spouse and /Or Children)

OTHER PLAN OFFERINGS

**PLEASE CALL LIFE PLUS INSURANCE AGENCY, INC DIRECTLY AT 781.837.9222
rgoodson@hilbgroup.com**

- Long Term Disability – payroll deduction only

**PLEASE CALL COLONIAL LIFE, KIMBERLY CUNNINGHAM AT 401.596.1510 OR EMAIL AT
KIMBERLY.CUNNINGHAM@COLONIALLIFESALES.COM**

- Disability Insurance - provides a monthly benefit to replace your income if you are unable to work due to a covered disability. Choose from a variety of plans. Now Covers Mental Health! (post-tax)
- Accident Insurance - pays a range of benefits for simple and complex accidents. Great for the whole family. (pre-tax)
- Medical Bridge - provides benefits to employees to help with the out-of-pocket expenses related to events such as hospital confinement, outpatient surgery, diagnostic tests and more. (pre-tax)
- Critical Illness with Cancer - pays you a lump sum to help cover your out-of-pocket expenses if diagnosed with a critical illness, such as a heart attack, cancer or stroke. (pre-tax)
- Whole Life Insurance - permanent life coverage - several plan options to select from to meet your needs and fit your budget. (post-tax)

U.S. LEGAL SERVICES FAMILY DEFENDER

_____ I would like to enroll in Family Defender coverage for **\$18.75 per month**.

_____ **I am presently declining coverage**

FLEXIBLE SPENDING ACCOUNT

If you elect to participate in the Flexible Spending Account you MUST complete the Enrollment Form to be submitted to Cafeteria Plan Advisors, Inc. If you are enrolled in the High Deductible plan, you CANNOT also contribute to the Flexible Spending Account.

I am aware that my deductions are to be taken pre-tax under Section 125 Cafeteria Tax Plan.

_____ I would like to enroll in FLEXIBLE SPENDING ACCT. **Administrative Fee \$60.00 Per Year**

_____ **I am presently declining coverage**

Employee Print Name: _____

Employee Signature: _____

Date: _____

I understand and agree that if I owe the Town of North Attleboro any money (for unpaid benefits, etc.), at the time my employment ends, the NASD may recoup that money by deducting it from my last paycheck.

Signature: _____ **Date:** _____