NORTH ATTLEBORO PUBLIC SCHOOLS

BENEFITS CHECKLIST for plans beginning July 1, 2022 to June 30, 2023

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)
***Note: 10 MONTH EMPLOYEES will pay an additional "catch-up" for July and August Premium (September through May)**

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

PLAN TYPE:	INDIVIDUAL RATE	FAMILY RATE
_____(HMO) NETWORK BLUE NEW ENGLAND DEDUCTABLE PLAN	$102.07	$267.50
_____(PPO) BLUE CARE ELECT DEDUCTABLE PLAN	$183.04	$455.52

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)
***Note: 10 MONTH EMPLOYEES will pay an additional two (2) mos. for July and August Premium (April through May)**

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

PLAN TYPE:

_____ I would like to enroll in an EMPLOYEE ONLY Plan **($1.66)**

_____ I would like to enroll in an EMPLOYEE & SPOUSE Plan (**$2.83)**

_____ I would like to enroll in an EMPLOYEE PLUS ONE OR MORE CHILDREN **($2.91)**

_____ I would like to enroll in a FAMILY **($4.57)**

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

_____I am presently declining coverage

BOSTON MUTUAL BASIC & VOLUNTARY TERM LIFE INSURANCE

Deductions are taken on the 2nd 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.
***Note: 10 MONTH EMPLOYEES will pay an additional two (2) mos. for July and August Premium in June on the 2nd pay of the month.**

_____I would like to enroll in the Basic Life Insurance Program ($5,000 coverage at $.94 cost per month -> 25% Employee Cost) ■**Total Monthly Premium:** $3.75 ■**Town Monthly Cost** (75%): $2.82 ■**Employee Monthly Cost** (25%): $0.94

_____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)

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

Amount of Insurance Employee $_____Cost $_____

(Employee **MUST** have coverage in order to insure spouse and /Or Children)

Dependent Life: Spouse $_____ Cost $_____

Child (ren) $_____ Cost $ _____

_____I am presently declining coverage

100% EMPLOYEE PAID BENEFITS

BLUE CROSS BLUE SHIELD OF MASSACHUSETTS DENTAL BLUE FREEDOM 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)
***Note: 10 MONTH EMPLOYEES will pay an additional two (2) mos. for July and August Premium (April through May)**

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

_____ I would like to enroll in an Individual Plan **($18.79)**

_____ I would like to enroll in a Family Plan **($54.62)**

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

_____ I am presently declining coverage

Blue Cross Blue Shield of Massachusetts Dental Blue
The annual maximus is: $1,250.00 per member per calendar year
The annual deductible is: $50.00 per individual / $150.00 per family
The maximum lifetime cap is: Unlimited
Dependent Coverage – Dependent children are covered up until the end of the month that they turn age 26

OTHER PLAN OFFERINGS FOR LIFE INSURANCE

- **PLEASE CALL LIFEPLUS INSURANCE AGENCY, INC DIRECTLY AT 781.837.9222**

  - Option Plus (Permanent Life) – billed at home or EFT
  - Accident Option Plus – billed at home or EFT
  - Critical Illness Plus – billed at home or EFT
  - Long Term Disability – payroll deduction only

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.

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 Signature:_____ **Date:**_____

OFFICE PROFESSIONALS AND PARAPROFESSIONALS ONLY

The NAFT Office Professionals & Paraprofessional collective bargaining agreements allow for employees covered under these agreements to have the following pay option: Pro-rate their salary over a twelve (12) month period. Notice of intent to receive pro-rated salary must be sent to payroll no later than July 1st preceding the new year.

Contact the Payroll Department, 508-643-2100 with your decision.