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

	#1. CHOOSE MEDICAL PLAN	#2. CHOOSE COVERAGE	#3. DENTAL COVERAGE
☐ I select the MEDICAL & DENTAL (complete #1, #2 & #3)	☐ SelectCare POS	☐ Employee Only	☐ Employee Only
	☐ TotalChoice	☐ Two Person	☐ Two Person
☐ I select DENTAL ONLY (complete #3)		☐ Family (Employee + 2 or more)	☐ 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 — Medical: ☐ Y ☐ N — Dental: ☐ Y ☐ N — Person Has Other Insurance: ☐ Y ☐ N

Name: ________________

Relationship: ____________ **Date of Birth:** __________ ☐ **Male** ☐ **Female** **SSN:** _________________

Coverage Election — Medical: ☐ Y ☐ N — Dental: ☐ Y ☐ N — Person Has Other Insurance: ☐ Y ☐ N

Name: ________________

Relationship: ____________ **Date of Birth:** __________ ☐ **Male** ☐ **Female** **SSN:** _________________

Coverage Election — Medical: ☐ Y ☐ N — Dental: ☐ Y ☐ N — Person Has Other Insurance: ☐ Y ☐ N

Name: ________________

Relationship: ____________ **Date of Birth:** __________ ☐ **Male** ☐ **Female** **SSN:** _________________

Coverage Election — Medical: ☐ Y ☐ N — Dental: ☐ Y ☐ N — Person Has Other Insurance: ☐ Y ☐ N

Name: ________________

Relationship: ____________ **Date of Birth:** __________ ☐ **Male** ☐ **Female** **SSN:** _________________

Coverage Election — Medical: ☐ Y ☐ N — Dental: ☐ Y ☐ N — Person Has Other Insurance: ☐ Y ☐ N

Name: ________________

Relationship: ____________ **Date of Birth:** __________ ☐ **Male** ☐ **Female** **SSN:** _________________

Coverage Election — Medical: ☐ Y ☐ N — Dental: ☐ Y ☐ N — Person Has Other Insurance: ☐ Y ☐ N

Name: ________________

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:** ________________________

STATE OF VERMONT
AGENCY OF ADMINISTRATION
(802)828-6700 Option1, Option3
DHR.Benefits@vermont.gov

Employee Benefits Unit
120 State Street, 5th floor
MONTPELIER, VT 05620-2505

Department of Human Resources

DOMESTIC PARTNER APPLICATION AND POLICY

Attached is the complete Domestic Partner Policy and an application to enroll a domestic partner on your health insurance and dental plan.

To enroll a domestic partner, you will need to do the following:

- Read the attached "Policy on Coverage for Domestic Partners under State Health Insurance Plans and Dental Plan". This policy defines domestic partners and children of domestic partners for benefit coverage purposes. Please be sure to read "Taxation of Benefits" on Page 5 of the policy. You need to be aware of the tax implications before applying for this coverage.

- Check the appropriate box on Page 1 of the application, indicating if the dependent(s) is or is not a qualified IRS dependent.

- You will also need to complete a "State of Vermont Enrollment/Change Form" which authorizes premium deductions to be withheld. You can obtain this form on the Benefits website at: **https://humanresources.vermont.gov/benefits-wellness/benefits/overview**

- Email only the 2-page application and the Enrollment/Change form to: DHR.Benefits@vermont.gov

Your application will be maintained in a confidential manner, as described in the attached policy.

STATE OF VERMONT

POLICY ON COVERAGE FOR DOMESTIC PARTNERS UNDER STATE HEALTH INSURANCE PLANS AND DENTAL PLAN

I. DEFINITIONS

A. A "Domestic Partner" is a person of the same or opposite sex as the eligible employee who meets the criteria set forth in the section of this Policy entitled "Coverage". Persons who live together for economic reasons but have not made a commitment to an exclusive enduring relationship as described in this Policy shall not be considered to be domestic partners.

B. A child of a domestic partner who meets the criteria set forth in the "Coverage" section of this Policy shall also be eligible for health and dental benefits under this Policy.

II. COVERAGE

A. Domestic Partners

An employee may obtain health and dental benefits coverage for his or her domestic partner by submitting an application, signed and sworn by the employee and the domestic partner, declaring that the domestic partner relationship meets all of the following criteria:

1. The persons are each other's sole domestic partner and have been in an enduring domestic relationship sharing a residence for not less than six consecutive months prior to the submission of the application.
2. The persons are eighteen years or older.
3. Neither person is married to anyone.
4. The parties are not related by blood closer than would bar marriage under Vermont state law.
5. The persons are competent to enter into a legally binding contract.
6. The persons have agreed between themselves to be responsible for each other's welfare.

B. Children of a Domestic Partner

An employee may obtain health and dental benefits coverage for the child of his or her domestic partner provided all of the following criteria are met:

1. The child otherwise meets the eligibility criteria for dependent children under the provisions of the health or dental benefit plans; and
2. The child can be, and is, claimed as a dependent by the employee and/or domestic partner for Federal income tax deduction purposes; and
3. The child resides with the employee and their domestic partner; and
4. The employee and their domestic partner have agreed between themselves to be jointly responsible for the child's welfare.

III. DOCUMENTATION AND VERIFICATION

The State may require you to produce documentary evidence to support the employee's request for insurance coverage for a domestic partner and the domestic partner's dependent children. Evidence to support the your request may include, but is not necessarily limited to, the following:

A. Evidence of joint purchase of home;
B. A copy of a lease for a residence identifying both parties as responsible for the payment of rent;
C. Evidence of a joint checking account;
D. Evidence of a joint savings account;
E. A title for a car showing joint ownership;
F. Evidence of joint liability for credit cards;
G. A copy of the plan proceeds form specifying that the domestic partner is the named beneficiary of state employee life insurance;
H. Evidence that the domestic partner is the beneficiary of the employee's deferred compensation;
I. Evidence of durable powers of attorney for property or health;
J. Wills specifying the domestic partner as the major recipient of employee's financial assets;
K. Or other forms of evidence depicting significant joint financial interdependency.

Any misrepresentation or falsification of information on an application or affidavit for health and dental benefit coverage under this Policy shall result in loss of health and dental insurance coverage, shall be considered gross misconduct, and may result in disciplinary action up to and including dismissal.

IV. OTHER PROVISIONS

A. Confidentiality

The application for benefits under this Policy shall be submitted directly to the Department of Human Resources, Employee Benefits and Wellness Division and shall contain the following statement: "I understand that this application and the information contained in it will be maintained by the State as a confidential personal document, and shall not be disclosed in the absence of the employee's written consent except as necessary to provide and administer benefits coverage or otherwise as required by law."

B. Termination of Domestic Partnership

The employee must notify the Department of Human Resources, Employee Benefits and Wellness Division, within 30 days after termination of a domestic partnership.

C. COBRA Coverage

Domestic partners and their dependents who are not considered as "qualifying beneficiaries" under federal COBRA provisions will not be eligible to continue their coverage under COBRA after any event that would otherwise give rise to COBRA rights, such as termination of employment or the relationship. Dependents who are not COBRA qualified may be eligible for continuation coverage under the State of Vermont law. Please contact the Employee Benefits Division for more information.

D. Taxation of Benefits – Extremely Important Information

The application for benefits under this Policy shall contain a statement to the effect that the State's portion of the cost of the health and dental benefits for a domestic partner or domestic partner's child(ren), when the partner or child is not an "IRS qualified" dependent of such employee, will be considered as taxable income to the employee and subject to withholding tax.

Section 152 of the Internal Revenue Code defines a dependent as an individual who received over half of their support from the taxpayer. Generally, a dependent can be claimed on the taxpayer's Federal Income Tax return. ***On the domestic partner application, if you certify that a domestic partner or domestic partner's child(ren) do not qualify as dependents under Section 152 of the Internal Revenue Code, the State's share of the cost of providing health care coverage to them is considered by the Internal Revenue Service as a taxable benefit to you***. If you enroll a domestic partner on your health insurance, your taxable wages for Federal Income Tax, Social Security, Medicare Wages and State Wages will include the State's share of the cost of the health care coverage provided to your domestic partner.

The amount of taxable income added to your wages on a biweekly basis for domestic partner coverage is based on the fair market value of the State's contributions toward this coverage. This applies to both medical and dental coverage. The State currently pays 80% of the cost of medical coverage and 100% of the cost of dental coverage. Also included would be any portion of the premium that you pay for this additional coverage that is deducted each pay period on a pre-tax basis.

E. Enrollment

An employee may obtain coverage under this Policy for a domestic partner or the child of a domestic partner during the annual Open Enrollment period as provided for by the plan; within 60 calendar days of qualifying for coverage under the "Coverage" section of this Policy; or in appropriate cases as provided for under the enrollment/eligibility provisions of the health plans.

STATE OF VERMONT

APPLICATION FOR HEALTH AND DENTAL COVERAGE FOR A DOMESTIC PARTNER AND THE DEPENDENT CHILDREN OF A DOMESTIC PARTNER

SECTION I: ENROLLMENT OF A DOMESTIC PARTNER

I, _____, swear that I and
(Print name of Employee)

_____are domestic partners, and we
(Print name of Domestic Partner)

certify that we meet all of the following criteria:

1. **We are each other's sole domestic partner and have been in an exclusive and enduring domestic relationship, while sharing a residence, for not less than six consecutive months prior to the submission of this application.**
2. **We are both eighteen years of age or older.**
3. **Neither one of us is married to anyone.**
4. **We are not related by blood closer than would bar marriage under Vermont State law.**
5. **We are both competent to enter into a legally binding contract.**
6. **We have agreed between ourselves to be responsible for each other's welfare.**

- I agree to notify the Vermont Department of Human Resources, Employee Benefits and Wellness Division within 30 calendar days after termination of this domestic partnership.
- I understand that I might be required to produce documentary evidence to support this application, in compliance with the Documentation and Verification Section of the Policy on Coverage for Domestic Partners Under Vermont State Health Insurance and Dental Plans.
- I understand that this application and the information contained in it will be maintained by the State as a confidential personal document, and shall not be disclosed in the absence of the employee's written consent except as necessary to provide and administer benefits coverage or otherwise as required by law.

PLEASE BE SURE TO READ "TAXATION OF BENEFITS" ON PAGE 5 BEFORE COMPLETING THIS SECTION.

I understand that if a domestic partner, or his/her child(ren), do not qualify as dependent(s) of the employee, under Section 152 of the Internal Revenue Code, *the cost of providing coverage for them will be considered taxable income to the employee and subject to tax withholding. In addition, I understand that if I terminate employment with the State and/or lose coverage under this plan or if my dependents lose coverage because our relationship ends, my non-qualified dependent(s) would not be eligible for COBRA Continuation Coverage.*

The partner identified above: IS ☐ IS NOT ☐ a qualified IRS dependent of the employee. (Check one)

SECTION II: ENROLLMENT OF CHILDREN OF A DOMESTIC PARTNER

I, _____, swear that my domestic partner
(Print Name of Employee)

is enrolled or is enrolling now as a dependent in the health and dental benefit plans of the State of Vermont, and I declare that his/her child(ren), whose names are listed below, meet all of the following criteria:

1. **The child otherwise meets the eligibility criteria for dependent children under the provisions of the health or dental plans, as outlined in the State employee benefit booklets; and**

2. **The child can be, and is, claimed as a dependent by me and/or my domestic partner for Federal Income tax deduction purposes; and**

3. **The child resides with me and my domestic partner; and**

4. **My domestic partner and I have agreed between ourselves to be jointly responsible for the child's welfare.**

Name of Child(ren)	Birth Date	Soc. Sec. #	IRS Dependent Of Employee?
1. _____			Yes ☐ No ☐
2. _____			Yes ☐ No ☐
3. _____			Yes ☐ No ☐

SECTION III: SIGNATURE

We understand that any misrepresentation of falsification of information on this application shall result in loss of health and dental insurance coverage, shall be considered gross misconduct, and may result in disciplinary action up to and including dismissal from employment.

We hereby swear, under penalty of perjury under the laws of the State of Vermont, that the foregoing is true and correct.

Dated: _____

_____ _____
Signature of Employee **Signature of Domestic Partner**

_____ _____
Social Security Number **Social Security Number**

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**