NEWTOWN PUBLIC SCHOOLS
EMPLOYEE MEDICAL AND DENTAL INSURANCE PLAN REQUIREMENTS

1. Changes during the plan year are permitted only if a qualified change in family or life status has occurred. Any requested change must be on account of and consistent with the change in family or life status.

2. I understand that I must notify Denise Hornyak in the Benefits Office at (203) 270-4569 within 30 days if any of the following family or life status changes occur:

   - ❖ Marriage, civil union, divorce, termination of civil union, death of a family member.
   - ❖ Birth or adoption of a child.
   - ❖ My dependent child age 21-26 is covered under a group health plan through their employer.
   - ❖ My dependent child stops attending school; your dependent child between 21 and 24 years of age must attend a qualified higher education institution as a full time student to be eligible for dental insurance coverage.

     - I understand that when my dependent reaches 26 years of age; he/she is not eligible for medical insurance coverage.

     - I understand that if my dependent is age 21-24, 'Proof of Student Status' forms are required each semester and must be completed by my dependent's school as proof of eligibility for dental coverage. I understand that when my full time student dependent reaches 25 years of age; he/she is not eligible for dental insurance coverage.

3. It is my responsibility to make sure that all family members who are eligible for medical insurance are properly enrolled.

4. If I have any changes in enrollment, I must complete the appropriate enrollment/change form; which can be obtained from Denise Hornyak.

5. If I enroll in the HSA after September 1st, the employer HSA funded annual deductible contribution amount will be pro-rated based on the number of months of coverage remaining in the insurance year (ending June 30).

6. If I terminate employment after July 1st, I am aware that the BOE will request a pro-rated amount of the employer HSA funded annual deductible contribution to be returned. The amount requested will be pro-rated based on the number of months of coverage received.

7. If I terminate employment I will be responsible for the employee insurance premium co-payments for the number of months of coverage received.

I hereby authorize the payroll department to make any appropriate payroll deductions for the coverage selected.

I have read and understand the Newtown Public Schools Employee Plan Requirements, and agree that these regulations shall be in effect for the duration of my employment.

_____ _____

Signature Date

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Printed Name