



February 1, 2023

To VSEA Members:

Open Enrollment for VSEA's vision plan is here and will continue until February 28th!

Automatic Renewal: If you are already enrolled in the plan and do not wish to make changes or request to terminate your plan, you will be automatically enrolled in the plan for the next year beginning 5/1/23 – 4/30/24.

New Enrollment or Changes: If you wish to enroll as a new member, terminate or make changes to your existing enrollment, print and complete the enrollment form below. New members must also include the appropriate payroll deduction form. Send completed forms directly to R.K. Tongue via fax (410-752-4611), encrypted scan/email to info@rktongue.com or regular mail (4940 Campbell Blvd., Ste 200, Nottingham, MD 21236). Remember to keep proof of submission for your records. All requests must be received no later than **2/28/23** in order to be processed for the upcoming plan year.

Payroll Deductions: Although the plan does not start until 5/1/23, payroll deductions will begin on the following dates:

- State employees and VSEA Housing – 04/08/23
- Retirees – 04/30/23
- Colleges – 03/31/23

ID Cards: VSP does not issue ID cards. Once enrolled, you will use your SSN when you see a provider. You can also print a temporary ID by logging into your account online.

Changes Mid-Year: Once enrolled, you may not voluntarily drop your coverage or make any changes until next open enrollment.

For any questions, please contact R.K. Tongue directly at 800-638-6353 or info@rktongue.com.

** Please note that VSEA charges a 60-cent administrative fee per pay period for insurance offered through RK Tongue Co., Inc. This is a flat rate and does not differ based on the number of insurance options you enjoy.

Please return this form to R.K. Tongue Co., Inc. via mail, fax (410-752-4611) or encrypted email to info@rktongue.com with VSEA Payroll Allotment Form by 2/28/23



Enrollment Form: VSEA VSP Vision Plan

Effective Date: 05/01/2023 – 04/30/24

Request Type: New Enrollee Change Termination^
 Enrollee Type: State College Retiree VT State Housing Auth

Employee Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

E-mail: _____ Employee ID: _____

Social Security No: _____ Date of Birth (MM/DD/YYYY): _____

Date of Hire (MM/DD/YYYY): _____ Phone/Cell: _____

<u>COVERAGE LEVEL:</u>	<u>TOTAL MONTHLY RATES**:</u>	<u>BI-WEEKLY RATES**:</u>
<input type="checkbox"/> Employee Only	\$9.86	\$4.56
<input type="checkbox"/> Employee + Spouse	\$19.70	\$9.10
<input type="checkbox"/> Employee + Child(ren)	\$21.08	\$9.73
<input type="checkbox"/> Employee + Family	\$33.70	\$15.56

** Please note that VSEA charges a 60-cent administrative fee per pay period for insurance offered through R.K. Tongue Co., Inc. This is a flat rate and does not differ based on the number of insurance options you enjoy.

^Termination Requests please complete name and sign below.

PLEASE LIST ALL OF YOUR DEPENDENTS THAT WILL BE ENROLLED OR REMOVED IN THE VISION PLAN:

A(dd) R(emove)	Last Name/First Name/MI	Dependent Type (CH, SP)	Date of Birth
<input type="checkbox"/> A <input type="checkbox"/> R			
<input type="checkbox"/> A <input type="checkbox"/> R			
<input type="checkbox"/> A <input type="checkbox"/> R			
<input type="checkbox"/> A <input type="checkbox"/> R			
<input type="checkbox"/> A <input type="checkbox"/> R			

Employee Signature _____

Date _____

NOTE: VSP VISION PLAN WILL ONLY STAY ACTIVE IF PAYMENTS ARE RECEIVED EACH PAY PERIOD. ONE NON-PAYMENT OF PREMIUM WILL RESULT IN IMMEDIATE TERMINATION OF YOUR VSP VISION BENEFITS. R.K. TONGUE DOES NOT BILL FOR VSP BENEFITS.

**VERMONT STATE EMPLOYEES ASSOCIATION
STATE OF VERMONT
EMPLOYEE REQUEST FOR PAYROLL DEDUCTION**

I hereby request the following action(s) for payroll deduction and authorize the Department of Finance & Information Support to withhold from my salary every pay check, the amount I have indicated below or an amount appropriate for my continued eligibility in the deduction plan. This request is effective this date and shall remain in effect until such time as I become ineligible or notify you in writing 10 days in advance that I want to cancel my deduction.

<p>DATE</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th colspan="5" style="text-align: center;">EMPLOYEE NUMBER</th> </tr> <tr> <td style="width: 20%; height: 20px;"></td> <td style="width: 20%; height: 20px;"></td> <td style="width: 20%; height: 20px;"></td> <td style="width: 20%; height: 20px;"></td> <td style="width: 20%; height: 20px;"></td> </tr> </table>	EMPLOYEE NUMBER										<p>BENEFITS -EMPLOYEE SIGNATURE</p> <p>DUES-VSEA MEMBERSHIP APPLICATION CARD</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th colspan="3" style="text-align: center;">EMPLOYEE NAME (PRINT)</th> </tr> <tr> <td style="width: 33%; height: 20px;"></td> <td style="width: 33%; height: 20px;"></td> <td style="width: 33%; height: 20px;"></td> </tr> <tr> <td style="text-align: center; font-size: small;">LAST</td> <td style="text-align: center; font-size: small;">FIRST</td> <td style="text-align: center; font-size: small;">MIDDLE</td> </tr> </table>	EMPLOYEE NAME (PRINT)						LAST	FIRST	MIDDLE
EMPLOYEE NUMBER																				
EMPLOYEE NAME (PRINT)																				
LAST	FIRST	MIDDLE																		

Instructions: As a permanent status State employee, you are eligible for payroll deduction of membership dues for the Vermont State Employees' Association. As a VSEA member, you may also elect to participate in various benefit programs offered by VSEA, for which an additional deduction will be made from your paycheck.

This form must be completed, in full, and sent to VSEA in order to initiate a payroll deduction from your wages for VSEA dues and/or member benefit program participation.

DO NOT CONFUSE THESE VSEA BENEFIT PROGRAMS WITH THE MEDICAL, DENTAL, OR LIFE INSURANCE PLANS OFFERED BY THE STATE OF VERMONT WHICH ARE AVAILABLE TO ALL PERMANENT STATE EMPLOYEES.

PLEASE NOTE: Insurance benefit programs offered by the VSEA are the sole responsibility of the VSEA. Payroll deduction of premiums for these programs should not be construed as an endorsement by the State of Vermont for either the member benefit program or the company offering that product. Contact the VSEA for more information on these programs and applicable costs.

MAIL OR DELIVER THIS FORM DIRECTLY TO:

VSEA Insurance
Vermont State Employees' Association, Inc.
155 State Street
Montpelier, VT 05601

<p>VSEA DUES</p> <p><input type="checkbox"/> START payroll deduction for VSEA Dues each pay period (Vermont State Police) Unit Dues</p> <p><input type="checkbox"/> STOP payroll deduction for VSEA Dues each pay period</p> <p>I understand that payroll deduction for the VSEA Member Benefit Programs is a privilege of VSEA membership and will terminate if I terminate VSEA membership</p> <p>VSEA MEMBER BENEFIT PROGRAMS</p> <p><input type="checkbox"/> START payroll deduction for each pay period</p> <p><input type="checkbox"/> START 60-cent administrative deduction each pay period</p> <p><input type="checkbox"/> INCREASE payroll deduction each pay period</p> <p><input type="checkbox"/> DECREASE payroll deduction each pay period</p> <p><input type="checkbox"/> STOP payroll deduction each pay period</p>	<p>VSEA DUES _____</p> <p>UNIT DUES _____</p> <p>TOTAL DUES _____</p> <p>PREVIOUS BENEFIT TOTAL _____</p> <p>+ _____</p> <p>+ _____</p> <p>+ _____</p> <p>- _____</p> <p>- _____</p> <p>NEW BENEFIT TOTAL _____</p> <p>TOTAL DEDUCTION (DUES AND BENEFITS) _____</p>
--	---

DATE _____

APPROVED _____
VSEA Authorized Representative

VERMONT RETIRED STATE EMPLOYEES ASSOCIATION

STATE OF VERMONT

RETIREE REQUEST FOR PENSION PAYROLL DEDUCTION

I hereby request the following action for pension payroll deduction, and I authorize the Retirement Office to withhold from my pension the amount indicated below, or an amount appropriate for my continued eligibility in the deduction plan. This request is effective this date and shall remain effective until such time as I become ineligible, or notify you in writing thirty (30) days in advance that I want to cancel my deduction.

RETIREE SIGNATURE **DATE**

PRINT RETIREE NAME (LAST FIRST MIDDLE)

_____|_____|_____|_____|_____|_____|

RETIREMENT NUMBER

_____|_____|_____|-|_____|_____|-|_____|_____|_____|

SOCIAL SECURITY NUMBER

INSTRUCTIONS: As a retired State employee, you are eligible for various benefit programs offered by the Association, for which a deduction will be made from your monthly pension payment. This form must be completed in full and sent to the VRSEA in order to initiate benefit program participation. **Please allow up to 30 days to process your application before deductions are taken. Do not confuse these VRSEA benefit programs with any benefit plan offered to all retired employees by the State of Vermont.**

PLEASE NOTE: Insurance benefit programs offered by the VRSEA are the sole responsibility of the VRSEA. Pension deductions of premiums for these programs should not be construed as an endorsement by the State of Vermont or its Retirement Systems for either the insurance product or the company offering that product. Contact the insurance representative (R. K. Tongue, Inc.) at (802) 223-0373 for more information on these programs and applicable premium rates.

MAIL OR DELIVER THIS FORM DIRECTLY TO:
 Vermont Retired State Employees Association
 P.O. Box 518 (or 155 State Street)
 Montpelier VT 05601-0518

TO: Retirement Accountant, State Treasurer's Office, Retirement Division
FROM: The Vermont Retired State Employees Association
SUBJ: VRSEA Deduction Transaction

\$ _____	If this Is a Change to an Existing Deduction, Please Indicate the Old Deduction:	\$ _____
NEW DEDUCTION		OLD DEDUCTION

VERMONT STATE EMPLOYEES ASSOCIATION VERMONT STATE COLLEGES

EMPLOYEE REQUEST FOR PAYROLL DEDUCTION

I hereby request the following action(s) for payroll deduction and authorize the Department of Finance & Information Support to withhold from my salary every pay check, the amount I have indicated below or an amount appropriate for my continued eligibility in the deduction plan. This request is effective this date and shall remain in effect until such time as I become ineligible or notify you in writing 10 days in advance that I want to cancel my deduction.

DATE	BENEFITS-EMPLOYEE SIGNATURE													
EMPLOYEE NUMBER	DUES-VSEA MEMBERSHIP APPLICATION CARD													
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; height: 20px;"></td> <td style="width: 25%; height: 20px;"></td> <td style="width: 25%; height: 20px;"></td> <td style="width: 25%; height: 20px;"></td> </tr> </table>					<table style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="3" style="text-align: center; border-bottom: 1px solid black;">EMPLOYEE NAME (PRINT)</td> </tr> <tr> <td style="width: 33%; height: 20px;"></td> <td style="width: 33%; height: 20px;"></td> <td style="width: 33%; height: 20px;"></td> </tr> <tr> <td style="text-align: center;">LAST</td> <td style="text-align: center;">FIRST</td> <td style="text-align: center;">MIDDLE</td> </tr> </table>	EMPLOYEE NAME (PRINT)						LAST	FIRST	MIDDLE
EMPLOYEE NAME (PRINT)														
LAST	FIRST	MIDDLE												

Instructions: As a permanent status VSC employee, you are eligible for payroll deduction of membership dues for the Vermont State Employees' Association. As a VSEA member, you may also elect to participate in various benefit programs offered by VSEA, for which an additional deduction will be made from your pay check. This form must be completed, in full, and sent to VSEA in order to initiate a payroll deduction from your wages for VSEA dues and/or member benefit program participation.

DO NOT CONFUSE THESE VSEA BENEFIT PROGRAMS WITH THE MEDICAL, DENTAL, OR LIFE INSURANCE PLANS OFFERED BY THE VT. STATE COLLEGES WHICH ARE AVAILABLE TO ALL PERMANENT VSC EMPLOYEES.

PLEASE NOTE: Insurance benefit programs offered by the VSEA are the sole responsibility of the VSEA. Payroll deduction of premiums for these programs should not be construed as an endorsement by the VSC for either the member benefit program or the company offering that product. Contact the VSEA for more information on these programs and applicable costs.

VSEA DUES	
<input type="checkbox"/> START payroll deduction for VSEA Dues each pay period	VSEA DUES _____
<input type="checkbox"/> STOP payroll deduction for VSEA Dues each pay period.	TOTAL DUES _____
<i>I understand that payroll deduction for the VSEA Member Benefit Programs is a privilege of VSEA membership and will terminate if I terminate VSEA membership.</i>	
VSEA MEMBER BENEFIT PROGRAMS	
<input type="checkbox"/> START payroll deduction each pay period	PREVIOUS BENEFIT TOTAL _____
<input type="checkbox"/> INCREASE payroll deduction each pay period	+ _____
<input type="checkbox"/> DECREASE payroll deduction each pay period	+ _____
<input type="checkbox"/> STOP payroll deduction each pay period	- _____
	- _____
	NEW BENEFIT TOTAL _____
	TOTAL DEDUCTION (DUES AND BENEFITS) _____

DATE: _____ APPROVED: _____

VSEA Authorized Representative

VERMONT STATE HOUSING AUTHORITY STAFF FEDERATION OF
THE VSEA
SUPPLEMENTAL INSURANCE/VT PAC
AUTHORIZATION FOR PAYROLL DEDUCTIONS

NAME: _____

ADDRESS: _____

PHONE: (_____) _____

I authorize the Vermont State Housing Authority to deduct the following _____ in the amount of _____ with the first pay period of each month effective _____ from my earnings, and to forward said deductions to the Treasurer of the VSHASF of the Vermont State Employees Association (V.S.E.A.). Any future additions/deletions to this amount shall require a new authorization.

Date: _____ Signature: _____

____ Personnel File
____ Accounting
____ VSEASF Treasurer