Town of Moretown

Road Crew Worker Job Opening

The full-time position includes winter road work, specifically operating a tandem truck equipped with plow and wings. Prior experience would be helpful, but we are willing to train the right person. Experience with performing maintenance, repair and construction on town roads would be helpful. The ability to work overtime, weekends and holidays in the winter plowing seasons is a must, and applicants must be able to report to work within 45 minutes of contact.

Applicants must hold a current valid driver's license and have the ability to lift heavy objects from time to time. Competitive pay commensurate with experience level. Great benefits.

Total Compensation: $75,000-$85,000

Applications and job description are available by calling 802-496-4141 or 802-882-8218 or by emailing mselectboard@moretownvt.net or snowman@madriver.com.

Applications are due at the Town Offices by 12:00 p.m. on October 7th, 2024 and can be emailed to both addressed above, or dropped off at the town garage located at 1320 Route 100B.

Questions should be addressed to Martin Cameron, Road Forman by calling 802-496-4141.

COMMERCIAL MOTOR VEHICLE OPERATOR

APPLICATION FOR EMPLOYMENT

COMPANY _____ STREET ADDRESS _____

CITY, STATE AND ZIP CODE _____

NAME _____
(FIRST) (MIDDLE) (Maiden Name, if any) (LAST)

ADDRESS _____ HOW LONG? _____
(STREET) (CITY) (STATE & ZIP CODE)

DATE OF BIRTH _____ SOCIAL SECURITY NO. _____ HIRE DATE _____

TELEPHONE NUMBER _____ E-MAIL ADDRESS _____

PREVIOUS THREE YEARS RESIDENCY

_____ # YEARS _____
(STREET) (CITY) (STATE & ZIP CODE)

_____ # YEARS _____
(STREET) (CITY) (STATE & ZIP CODE)

_____ # YEARS _____
(STREET) (CITY) (STATE & ZIP CODE)

(ATTACH SHEET IF MORE SPACE IS NEEDED)

LICENSE INFORMATION

Section 383.21 FMCSR states, "No person who operates a commercial motor vehicle shall at any time have more than one driver's license". I certify that I do not have more than one motor vehicle license, the information for which is listed below.

STATE	LICENSE NO.	TYPE	EXPIRATION DATE

DRIVING EXPERIENCE

CLASS OF EQUIPMENT	TYPE OF EQUIPMENT (VAN, TANK, FLAT, ETC.)	DATES FROM	DATES TO	APPROX. NO. OF MILES (TOTAL)
STRAIGHT TRUCK				
TRACTOR AND SEMI-TRAILER				
TRACTOR – TWO TRAILERS				
OTHER				

ACCIDENT RECORD FOR PAST 3 YEARS OR MORE (ATTACH SHEET IF MORE SPACE IS NEEDED)

DATES	NATURE OF ACCIDENT (HEAD-ON, REAR-END, UPSET, ETC.)	NUMBER FATALITIES	NUMBER INJURIES	CHEMICAL SPILLS
				YES ☐ NO ☐
				YES ☐ NO ☐
				YES ☐ NO ☐

TRAFFIC CONVICTIONS AND FORFEITURES FOR THE PAST 3 YEARS (OTHER THAN PARKING VIOLATIONS)

DATE CONVICTED (month/year)	VIOLATION	STATE OF VIOLATION LOCATION	PENALTY (forfeited bond, collateral and/or points)

(ATTACH SHEET IF MORE SPACE IS NEEDED)

A. Have you ever been denied a license, permit or privilege to operate a motor vehicle? YES _____ NO _____

If yes, explain _____

B. Has any license, permit or privilege ever been suspended or revoked? YES _____ NO _____

If yes, explain _____

EMPLOYMENT RECORD
(ATTACH SHEET IF MORE SPACE IS NEEDED)

Applicants that desire to drive in intrastate/interstate commerce must provide the following information on all employers during the previous three years. You must give the same information for all employers you have driven a commercial motor vehicle for the seven years prior to the initial three years (total of ten years employment record).

Must list the complete mailing address: street number and name, city, state and zip code.

LAST EMPLOYER: NAME _____
ADDRESS _____ PHONE _____
POSITION HELD _____ FROM _____ TO _____
REASONS FOR LEAVING _____
ANY GAPS IN EMPLOYMENT AND/OR UNEMPLOYMENT MUST BE EXPLAINED. INCLUDE DATES (MONTH/YEAR) AND REASON.

_____

Were you subject to the Federal Motor Carrier Safety Regulations (FMCSRs) while employed by the previous employer? Yes ☐ No ☐
Was the previous job position designated as a safety sensitive function in any DOT regulated mode, subject to alcohol and controlled substances testing requirements as required by 49 CFR Part 40? Yes ☐ No ☐

SECOND LAST EMPLOYER: NAME _____
ADDRESS _____ PHONE _____
POSITION HELD _____ FROM _____ TO _____
REASONS FOR LEAVING _____
ANY GAPS IN EMPLOYMENT AND/OR UNEMPLOYMENT MUST BE EXPLAINED. INCLUDE DATES (MONTH/YEAR) AND REASON.

_____

Were you subject to the Federal Motor Carrier Safety Regulations (FMCSRs) while employed by the previous employer? Yes ☐ No ☐
Was the previous job position designated as a safety sensitive function in any DOT regulated mode, subject to alcohol and controlled substances testing requirements as required by 49 CFR Part 40? Yes ☐ No ☐

THIRD LAST EMPLOYER: NAME _____
ADDRESS _____ PHONE _____
POSITION HELD _____ FROM _____ TO _____
REASONS FOR LEAVING _____
ANY GAPS IN EMPLOYMENT AND/OR UNEMPLOYMENT MUST BE EXPLAINED. INCLUDE DATES (MONTH/YEAR) AND REASON.

_____

Were you subject to the Federal Motor Carrier Safety Regulations (FMCSRs) while employed by the previous employer? Yes ☐ No ☐
Was the previous job position designated as a safety sensitive function in any DOT regulated mode, subject to alcohol and controlled substances testing requirements as required by 49 CFR Part 40? Yes ☐ No ☐

TO BE READ AND SIGNED BY APPLICANT

I authorize you to make sure investigations and inquiries to my personal, employment, financial or medical history and other related matters as may be necessary in arriving at an employment decision (generally, inquiries regarding medical history will be made only if and after a conditional offer of employment has been extended). I hereby release employers, schools, health care providers and other persons from all liability in responding to inquiries and releasing information in connection with my application.
In the event of employment, I understand that false or misleading information given in my application or interview(s) may result in discharge. I understand, also, that I am required to abide by all rules and regulations of the Company.
"I understand that information I provide regarding current and/or previous employers may be used, and those employer(s) will be contacted, for the purpose of investigating my safety performance history as required by 49 CFR 391.23(d) and (e). I understand that I have the right to:

- Review information provided by current/previous employers;
- Have errors in the information corrected by previous employers and for those previous employers to re-send the corrected information to the prospective employer; and
- Have a rebuttal statement attached to the alleged erroneous information, if the previous employer(s) and I cannot agree on the accuracy of the information."

_____ _____
DATE APPLICANT'S SIGNATURE

This certifies that I completed this application, and that all entries on it and information in it are true and complete to the best of my knowledge.

_____ _____
DATE APPLICANT'S SIGNATURE

Note: A motor carrier may require an applicant to provide information in addition to the information required by the Federal Motor Carrier Safety Regulations.

Pre-Employment CDL Driver Qualification File Checklist

This document can serve as a hiring checklist to help the municipality make sure that it is complying with the Federal CDL hiring requirements. Each driver's qualification file (DQF) must be retained for as long as a driver is employed and for three years thereafter §391.51(c). The DQF must include documents from ongoing recordkeeping (see the *Recordkeeping* section for more details) as well as the pre-employment documents listed below:

☐ A completed CDL job application for each CMV driver, in accordance with §391.21 **(required).** (This is not a standard job application). A sample is provided in the later pages of this section.

☐ The driver qualification file elements from previous employers (§391.23). This includes employment record, accident history, and alcohol and controlled substance testing records for the preceding 3 years from any DOT regulated employer. If the records are not obtained from prior employer(s), evidence of the attempt must be retained. All above documents must be maintained per §391.53. An employment history/drug & alcohol testing request form is provided in the later pages of this section.

☐ Acceptable pre-employment drug test results or exemption form filled out by previous employer (**required**). NOTE: VLCT recommends each new employee undergo pre-employment drug testing and that the municipality not utilize the exemption. Contact Occupational Drug Testing to schedule the pre-employment test.

☐ Pre-employment motor vehicle records check results for prior 3 years from each state in which the driver has operated a commercial motor vehicle (**required by§391.23(a)(1)**). This may require contacting states other than Vermont. A copy of the Vermont DMV motor vehicle records request form is provided in the later pages of this section and is also available on the Vermont DMV website (note that the document is 2 pages).

☐ The certificate of driver's road test issued to the driver, or a copy of the commercial driver license (**required by §391.31(e)**). VLCT/PACIF recommends that an actual road test be given to potential new hires.

☐ (OPTIONAL) The DOT certified medical examiner's certificate of his/her physical qualification to drive a commercial motor vehicle as required by §391.43(f) or a legible photographic copy of the certificate. **(Note: this is a "best practice" recommendation, as municipalities are typically exempt from this requirement). We suggest that the municipality establish a policy requiring CDL drivers to maintain their medical certification card. This best practice should start at hire and continue though the duration of employment.**

NOTES

- Driver records must be maintained in a secure manner, similar to personnel records-but should be separate.
- Additional information can be obtained from VLCT loss control staff and at: http://www.fmcsa.dot.gov/safety-security/eta/index.htm
- In the event that Occupational Drug Testing is unable to meet an urgent schedule for hiring a new CDL driver, they will direct you to the nearest certified clinic so that the pre-employment testing can be performed within a reasonable timeframe.

Employment History and CDL Drug & Alcohol Testing Request Form

Your Entity Name			
Mailing Address			
Telephone & Fax #s			
Contact Person			
Email Address			
Driver Applicant Name		Social Security #	

I hereby authorize and request [Enter Name of Prior Employer, Address & Telephone #]

_____

to release any and all information pertaining to my employment records to the above requesting prospective employer as required by 49 CFR Section 391.23 and Section 40.25(b). You are released from any and all liability which may result from releasing such information. The Federal Motor Carrier Safety Regulations require that this information be released as part of the Driver Qualification Process. Per 49 CFR Section 40.25(h), you are required to immediately release this information to the above requesting employer.

Guidance to Prior Employers

Per 391.23(f) the driver's written consent is provided to the previous employer to ensure the proper release of information required by FMCSA regulations. (g) Employers must:

(g)(1) Respond to each request for the DOT defined information in paragraphs (d) and (e) of this section within 30 days after the request is received (Drug and Alcohol Testing Information must be immediately released). If there is no safety performance history information to report for that driver, previous motor carrier employers are nonetheless required to send a response confirming the non-existence of any such data, including the driver identification information and dates of employment.

(g)(2) Take all precautions reasonably necessary to ensure the accuracy of the records.

(g)(3) Provide specific contact information in case a driver chooses to contact the previous employer regarding correction or rebuttal of the data.

(g)(4) Keep a record of each request and the response for one year, including the date, the party to whom it was released, and a summary identifying what was provided.

Driver Printed Name: _____

Driver Signature: _____ Date: _____

Witnessed by: _____

Employment History and CDL Drug & Alcohol Testing Request Form

Controlled Substance and Alcohol Testing Information–sections 382.413 and 40.259(b)

1. Was the above named individual in a random DOT compliant drug & alcohol testing program during his/her employment with your company? ☐ Yes ☐ No

2. Has the above named individual had an alcohol test with a breath alcohol concentration of 0.04 or greater while in your employ? ☐ Yes ☐ No

3. Has the above named individual had a controlled substance test with a positive result while in your employ? ☐ Yes ☐ No

4. Has the above individual refused a controlled substance test or alcohol test while in your employ? ☐ Yes ☐ No

5. Other violations of DOT Agency Drug and Alcohol testing regulations? ☐ Yes ☐ No
   Addition Info Attached ☐ Yes ☐ No

6. Do you have documentation of the employee's successful completion of the 49 CFR Subpart O return to duty requirements? ☐ Yes ☐ No ☐ Not Applicable

With Reference to **question number 5**, please identify the Substance Abuse Professional you referred the driver to if he/she tested positive or refused testing.

Name:	
Mailing Address	
Phone #	

Signed by: _____ Date: _____

Printed Name: _____

Prior Employer Official Title: _____

NOTE: You are required to release this information immediately per 49 CFR 382.405(f) & 40.25(h). Fines and penalties for not releasing this information is found in 49 CFR 382.507 under 49 USC 521(b).

We reserve the right to notify the US DOT Federal Motor Carrier Safety Administration in the event the above information is not received.

Reply Mailed On: _____

Verified by Phone: ☐ Yes ☐ No

Person Contacted: _____

Signature: _____ Date: _____

Applicant Acknowledgement of Drug & Alcohol Testing Requirement

Job Title Applied for: _____

Municipality: _____

I understand that as a condition of employment, I must successfully complete a drug test as required by 49 CFR Part 655, Part 382 and Part 40, when requested by the employer. I also understand that the employer may administer an optional pre-employment alcohol test if they so desire.

I understand that a negative drug test is required before I will be permitted to perform safety-sensitive duties. If a pre-employment alcohol test is administered, I understand that it must also be negative. I also understand that if I fail the required drug test or optional alcohol test that I will be eliminated from consideration for the above position and any contingent offer of employment for that position will be withdrawn.

Printed Applicant Name: _____

Applicant Signature: _____

Printed Name (Witness): _____

Witness Signature: _____

Date: _____

Employment History and CDL Drug & Alcohol Testing Request Form

Your Entity Name			
Mailing Address			
Telephone & Fax #s			
Contact Person			
Email Address			
Driver Applicant Name		Social Security #	

I hereby authorize and request [Enter Name of Prior Employer, Address & Telephone #]

_____

to release any and all information pertaining to my employment records to the above requesting prospective employer as required by 49 CFR Section 391.23 and Section 40.25(b). You are released from any and all liability which may result from releasing such information. The Federal Motor Carrier Safety Regulations require that this information be released as part of the Driver Qualification Process. Per 49 CFR Section 40.25(h), you are required to immediately release this information to the above requesting employer.

Guidance to Prior Employers

Per 391.23(f) the driver's written consent is provided to the previous employer to ensure the proper release of information required by FMCSA regulations. (g) Employers must:

(g)(1) Respond to each request for the DOT defined information in paragraphs (d) and (e) of this section within 30 days after the request is received (Drug and Alcohol Testing Information must be immediately released). If there is no safety performance history information to report for that driver, previous motor carrier employers are nonetheless required to send a response confirming the non-existence of any such data, including the driver identification information and dates of employment.

(g)(2) Take all precautions reasonably necessary to ensure the accuracy of the records.

(g)(3) Provide specific contact information in case a driver chooses to contact the previous employer regarding correction or rebuttal of the data.

(g)(4) Keep a record of each request and the response for one year, including the date, the party to whom it was released, and a summary identifying what was provided.

Driver Printed Name: _____

Driver Signature: _____ Date: _____

Witnessed by: _____

Employment History and CDL Drug & Alcohol Testing Request Form

Employment History

If the individual listed was not a CDL driver or in a safety sensitive position that required him/her to be in a DOT Drug & Alcohol Testing program, check here: ☐

The above applicant states that he/she was employed by you between the following dates:

From: _____ To _____

Please indicate the following:

1. Commercial Motor Vehicle Type

☐ Straight Truck
☐ Van
☐ Flatbed
☐ Dump Truck/Logging Truck
☐ Other (please indicate vehicle type(s) _____

☐ Tractor/Semi trailer
☐ Bus
☐ Cargo/Tanker

2. Was the applicant safe and efficient? ☐ Yes ☐ No

Remarks:

3. Did the applicant have any motor vehicle accidents while in your employ? ☐ Yes ☐ No
If yes, please describe details, outcome, and severity of accident.

4. Reason for leaving your employ: ☐ Discharged ☐ Laid off ☐ Resigned
☐ Other (please describe):

Please rate the driver for the following characteristics, using a check mark:

Characteristics	Excellent	Average	Poor
Quality of work			
Cooperation with others			
Safety Habits			
Personal Habits			
Driving Skills			
Attitude			

BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association

Small Group Coverage

Enrollment and Change Form

Please provide all information and print in ink or type.

Submit one of three ways: email, fax, or mail.
See page 2 for more information.

Requested effective date / /

Section 1: EMPLOYER/EMPLOYEE INFORMATION

Group name:

Group/account no.:

Plan Selection:
☐ Platinum ☐ Gold ☐ Silver ☐ Bronze ☐ Silver CDHP ☐ Bronze CDHP
Blue Rewards Health and Wellness Program℠ Plans:
☐ Blue Rewards Gold ☐ Blue Rewards Gold CDHP
☐ Blue Rewards Silver ☐ Blue Rewards Bronze CDHP

Last name:	First name:	Social Security number**** (SSN):
Mailing address:	City:	State: / ZIP code:
Phone number:	Email address:	Primary Care Physician (PCP) name, or NPI number: Are you a current patient? ☐ Yes ☐ No
Date of birth (DOB): / Gender: ☐ Male ☐ Female	Marital status: ☐ Single ☐ Widowed ☐ Married/party to a civil union ☐ Domestic Partner**	Employment status: ☐ Active ☐ Retired ☐ Continuation

Health coverage type: ☐ Employee only ☐ Employee/spouse *(including party to a civil union/domestic partner)* ☐ Employee/children ☐ Family

Section 2: NEW ENROLLMENT *(Check one, then go to SECTION 4)*

☐ New group ☐ Open enrollment ☐ New hire/re-hire ☐ Continuation of coverage (COBRA/VIPER) ☐ Refusal ☐ Spouse turning age 65
☐ Transferred from another BCBSVT plan Transferring from certificate no. ____________

Section 3: CHANGE/CANCELLATION

Change: *Effective date* ___/___/______

☐ Birth
☐ Adoption placement date ___/___/______
☐ Marriage/Civil Union
☐ Divorce
☐ Address change
☐ Name change
☐ PCP change
☐ Court ordered change**
☐ Loss of coverage**

Cancel: *Date of cancellation* ___/___/______

☐ Voluntary cancel *(signature required)* ____________
☐ Left employment *(group benefits manager signature)* ____________
☐ Other (explain) ____________

Section 4: LIST ALL DEPENDENTS BELOW TO BE ADDED OR REMOVED

Dependent Information **** Important note: Federal Law mandates our collection of SSN for all members over 45.

Primary Care Physician (PCP) Information *(If Managed Care)*

Dependent Information	SSN / DOB	Gender	PCP Information
☐ Add ☐ Remove *(Spouse/party to a civil union/domestic partner)* Last Name First Name	SSN**** DOB	Gender ☐ Male ☐ Female	PCP Name NPI No.*** Are you a current patient? ☐ Yes ☐ No
☐ Add ☐ Remove Last Name First Name	SSN**** DOB	Gender ☐ Male ☐ Female	PCP Name NPI No.*** Are you a current patient? ☐ Yes ☐ No
☐ Add ☐ Remove Last Name First Name	SSN**** DOB	Gender ☐ Male ☐ Female	PCP Name NPI No.*** Are you a current patient? ☐ Yes ☐ No
☐ Add ☐ Remove Last Name First Name	SSN**** DOB	Gender ☐ Male ☐ Female	PCP Name NPI No.*** Are you a current patient? ☐ Yes ☐ No
☐ Add ☐ Remove Last Name First Name	SSN**** DOB	Gender ☐ Male ☐ Female	PCP Name NPI No.*** Are you a current patient? ☐ Yes ☐ No
☐ Add ☐ Remove Last Name First Name	SSN**** DOB	Gender ☐ Male ☐ Female	PCP Name NPI No.*** Are you a current patient? ☐ Yes ☐ No

 Please see section 6 on page 2 for subscriber signature

Group name:	Employee name:

Section 5: OTHER INSURANCE INFORMATION

If you obtain health insurance coverage with us, will you or any of your dependents be covered with another health or dental insurance plan (including Medicare or Medicaid)?

☐ Yes *(please complete the applicable section below)* ☐ No

MEDICAL

Insurance company (name and address)		
Policyholder name	Policy certificate no.	Group no.
Effective date	Type of coverage ☐ 1-person ☐ 2-person ☐ Family	

DENTAL

Insurance company (name and address)		
Policyholder name	Policy certificate no.	Group no.
Effective date	Type of coverage ☐ 1-person ☐ 2-person ☐ Family	

Section 6: SUBSCRIBER SIGNATURE

I certify that the statements on this application and all information I've furnished is true and complete to the best of my knowledge. I authorize any health care provider to disclose to Blue Cross and Blue Shield of Vermont, or its designated agent, any information acquired in connection with my past or future care or treatment or that of any dependent named herein or hereafter added to my coverage. I understand that no right whatsoever is created by this application and that the same shall not be considered accepted unless and until the contract is actually issued by Blue Cross and Blue Shield of Vermont. I UNDERSTAND THAT MY BENEFITS ARE GOVERNED BY THE PROVISIONS OF MY CERTIFICATE AND OUTLINE OF COVERAGE.

SIGN HERE

▶ Employee's signature _____ date _____ ◀

Submit one of three ways:

Email:	Fax:	Mail:
asinbox@bcbsvt.com	(802) 371-3329	Blue Cross Blue Shield of Vermont P.O. Box 186 Montpelier, VT 05601-0186

If you are adding a dependent child, age 26 or older, contact customer service at (888) 320-9798 for further instructions.

* = Includes Party to a Civil Union or Domestic partner

** = Additional Documentation Required

*** = See our "Find-a-Doctor" tool at **www.bcbsvt.com/findadoctor**

**** = SSN required age 45 and older (Federal mandate requires the collection of SSN)

DELTA DENTAL

HOW HEALTH through ORAL WELLNESS

Delta Dental Plan of Maine
Delta Dental Plan of New Hampshire
Delta Dental Plan of Vermont

DENTAL ENROLLMENT / CHANGE FORM

PLEASE TYPE OR PRINT LEGIBLY – IN BLUE OR BLACK INK ONLY

Please send form to:
Northeast Delta Dental
One Delta Drive
PO Box 2002
Concord, NH 03302-2002
1-800-537-1715
(603)223-1230 Eligibility
(603)223-1252 Eligibility Fax
NortheastDeltaDental.com

1. SUBSCRIBER INFORMATION - To be completed by Employee

LAST NAME (SUBSCRIBER)	FIRST NAME	SOCIAL SECURITY / I.D. #	SEX ☐M ☐F	DATE OF BIRTH (MM-DD-YYYY)

MAILING ADDRESS	CITY	STATE	ZIP	TELEPHONE NO.
				( )

MARITAL STATUS ☐ SINGLE ☐ WIDOWED ☐ DIVORCED ☐ DOMESTIC PARTNER ☐ MARRIED

E-MAIL ADDRESS TO RECEIVE HEALTH THROUGH ORAL WELLNESS® (HOW®) MESSAGES

2. GROUP INFORMATION - To be completed by Employer

GROUP NAME	STREET ADDRESS, CITY, STATE, ZIP

GROUP NUMBER	SUBLOCATION NUMBER	DIVISION	MISC. INFO (i.e. STORE LOC)

EFFECTIVE DATE (MM-DD-YYYY)	EMPLOYEE DATE OF HIRE (MM-DD-YYYY)	EMPLOYEE DATE OF REHIRE (MM-DD-YYYY)	IF DUAL OPTION, SELECT PLAN
– –	– –	– –	☐N/A ☐LOW ☐HIGH

3. REASON FOR ENROLLMENT/CHANGE - Check all appropriate boxes

EXACT DATE OF STATUS CHANGE – – (MM-DD-YYYY)

ADD:
- ☐ New enrollment
- ☐ Annual open enrollment
- ☐ COBRA Due to:
- ☐ Marriage
- ☐ Birth ☐ Other:
- ☐ Adoption
- ☐ Employment change for spouse
- ☐ Part-time to full-time employment status

DELETE:
- ☐ Annual open enrollment
- ☐ Employment change for spouse
- ☐ Full-time to part-time employment status
- ☐ Divorce
- ☐ Deceased
- ☐ Retirement
- ☐ Other Coverage
- ☐ Other_____

MISCELLANEOUS CHANGE:
- ☐ Name change – Previous name: _____
- ☐ Transfer from sublocation: _____
- ☐ Address change
- ☐ Other: _____

COVERAGE LEVEL REQUESTED
- ☐ Subscriber Only ☐ Subscriber & Spouse ☐ Subscriber & Child
- ☐ Subscriber & Children ☐ Family

4. DEPENDENT INFORMATION - List all dependents to be newly enrolled, or those dependents who are affected by an addition or deletion listed above in section #3. If you are enrolling some but not all of your eligible dependents, your other dependents must have coverage elsewhere.

LAST NAME (IF DIFFERENT)	FIRST NAME	DATE OF BIRTH MM-DD-YYYY	SEX M/F	RELATIONSHIP TO SUBSCRIBER	*	ADD/ DELETE	E-MAIL FOR SPOUSE AND/OR DEPENDENTS OVER THE AGE OF 18

*Check if dependent is incapacitated. Legal documentation may be required.

5. OTHER GROUP COVERAGE (COORDINATION OF BENEFITS)

Will this dental coverage replace another Northeast Delta Dental Plan? ☐ Yes ☐ No **If yes, complete the following:**

POLICYHOLDER ID # / SOCIAL SECURITY #	EFFECTIVE DATE (MM-DD-YYYY)
	– –

Statements made in this document are deemed to be representations and not warranties. I represent that all information is true and correct to the best of my knowledge. I understand that by not choosing a network provider for myself or any family member, I may be responsible for higher out-of-pocket expenses. I also understand that the effective date and termination date of my membership will be determined by my employer or plan sponsor in accordance with the underwriting guidelines of Northeast Delta Dental. If my employer or plan sponsor requires employee contributions for this coverage, I authorize the deductions of these amounts from my wages. I further authorize my employer or plan sponsor to deduct any premium which is owed by me as of the date my application is approved. I understand that my dependents and I must remain enrolled and can discontinue our coverage only during open enrollment, except in the event of a qualified family status change. **By signing below I hereby accept coverage. This policy provides dental benefits only. Review your policy carefully.**

SUBSCRIBER SIGNATURE (REQUIRED): _____ DATE: _____

Fax form to 513-492-3605 or
email to enroll@eyemed.com

Enrollment/Change Form

Please print in all capital letters using blue or black ink. Please complete all sections. Required sections are marked with an *.

Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri

Employer Information: to be completed by Employer

Employer Name* | Effective Date*^ (__ / __ / ____)

Group Number* | Subgroup* (1001) | Class | Plan

^Date set by employer in accordance with EyeMed proposal. Employer also sets effective date for new adds during contract period.

Location Code | Division Code

Employee Information: to be completed by Employee

Change Type*: ☐ Add ☐ Term ☐ Update | Member ID:

Last Name* | Date of Birth* (__ / __ / ____)

First Name* | MI | Gender* ☐ Male ☐ Female | Phone Number ( ) -

Street Address*

City* | State* | Zip Code* | Social Security Number*^ - -

^Last four digits of Employee's Social Security Number are required.

Employee Email Address:

Family Information: to be completed by Employee. Only eligible dependents may be enrolled.

Dependent 1

Change Type*: ☐ Add ☐ Term ☐ Update

Relationship*: ☐ Husband ☐ Wife ☐ Son ☐ Daughter ☐ Domestic Partner

Last Name* | Gender*: ☐ Male ☐ Female

First Name* | MI | Social Security Number - - | Date of Birth* (__ / __ / ____)

Dependent 2

Change Type*: ☐ Add ☐ Term ☐ Update

Relationship*: ☐ Husband ☐ Wife ☐ Son ☐ Daughter ☐ Domestic Partner

Last Name* | Gender*: ☐ Male ☐ Female

First Name* | MI | Social Security Number - - | Date of Birth* (__ / __ / ____)

Dependent 3

Change Type*: ☐ Add ☐ Term ☐ Update

Relationship*: ☐ Husband ☐ Wife ☐ Son ☐ Daughter ☐ Domestic Partner

Last Name* | Gender*: ☐ Male ☐ Female

First Name* | MI | Social Security Number - - | Date of Birth* (__ / __ / ____)

Dependent 4

Change Type*: ☐ Add ☐ Term ☐ Update

Relationship*: ☐ Husband ☐ Wife ☐ Son ☐ Daughter ☐ Domestic Partner

Last Name* | Gender*: ☐ Male ☐ Female

First Name* | MI | Social Security Number - - | Date of Birth* (__ / __ / ____)

I hereby represent that I have reviewed the fraud warning notice on the reverse side of this application for the Employee's resident state.

Employee Signature*: _____ Date*: __ / __ / ____

For additional dependents, please complete a second form.

A-01225

Insurance Benefit Enrollment Form

Employee: Complete and return this form to your Benefits Administrator.

NIS National Insurance Services

Benefits Administrator: Retain a copy of this form for your records and provide employee with a copy. Mail original to:
National Insurance Services, Attn: Billing Department
250 S. Executive Drive, Suite 300, Brookfield, WI 53005-4273
Phone: 1.800.627.3660 Fax: 262.814.1397

Enter your information:

Employer Name:			NIS Group Number:	
Full Name (Last name, First name, Middle Initial):			Date of Hire:	
Home Address:		City:	State:	Zip:
Social Security Number:	☐ Single ☐ Married	U.S. Citizen? ☐ Yes ☐ No*	Date of Birth:	☐ Male ☐ Female
Occupation/Title:	Date Benefit Eligible:		Hours worked per week:	Annual Salary:

*If you are not a U.S. Citizen, please provide a copy of your Visa.

Insurance benefits:

Optional Insurance Benefits:

☐ Elect	☐ Decline	Employee Supplemental Life and AD&D Amount: $_____ - You can elect an amount in $10,000 increments, up to a maximum of $100,000 (not to exceed 5x your annual salary) - Evidence of Insurability is required for amounts over $10,000 if the employee is over age 70
☐ Elect	☐ Decline	Spouse Supplemental Life and AD&D Amount: $_____ - You can elect an amount in $5,000 increments, up to a maximum of $30,000 (cannot exceed 50% of the Employee Supplemental Life and AD&D amount) - Evidence of Insurability is required for any amount if the spouse is over age 60 - Coverage is not available for spouses over age 70
☐ Elect	☐ Decline	Child Supplemental Life - $10,000 in coverage for child(ren) age 6 months to 19 years (or 25 years if a full time student) - $250 in coverage for children age 14 days to 6 months)

Sign here (required whether electing or declining any coverage):

I have been given the opportunity to apply for group insurance and agree to accept or decline coverage(s) as noted above. If I am declining coverage(s), I understand that if my dependents or I decide to apply for coverage at a later date, Evidence of Insurability (medical questions) may be required at my own expense and the insurance company must approve coverage. If I have elected any coverage(s) above, I authorize my employer to make any required deductions, if any, from my salary to pay my portion of the insurance premium when my insurance becomes effective.

Warning: Any person who knowingly presents false information on an application for insurance may be guilty of a crime and subject to fines, confinement in prison, and/or denial of insurance benefits.

Signature:	Date:

More on other side ----------→

Full Name:	Employer Name:	Date:

Enter your Life Insurance beneficiary information:

Primary Beneficiary(ies) Attach additional pages if necessary.			
Full Name:	Relationship to you:	Address & Phone:	% of Benefit:
Full Name:	Relationship to you:	Address & Phone:	% of Benefit:
Full Name:	Relationship to you:	Address & Phone:	% of Benefit:
Secondary Beneficiary(ies) Attach additional pages if necessary.			
Full Name:	Relationship to you:	Address & Phone:	% of Benefit:
Full Name:	Relationship to you:	Address & Phone:	% of Benefit:
Full Name:	Relationship to you:	Address & Phone:	% of Benefit:

Spouse's Signature (May be required if choosing a primary beneficiary other than your spouse. Under state law a beneficiary other than your spouse may not be honored unless your spouse signs below. Please consult with your legal advisor before making such a designation.)

Spouse's Name:	Signature:	Date:

Add spouse/dependent information:

Please provide the following information if electing Dependent Coverage. Attach additional pages if necessary.

Full Name		Date of Birth	Social Security #	Full-Time Student?
Spouse:	Date of Marriage:			n/a
Child:				☐ Yes ☐ No
Child:				☐ Yes ☐ No
Child:				☐ Yes ☐ No
Child:				☐ Yes ☐ No
Child:				☐ Yes ☐ No

Sign here:

Signature:	Date:

More on next page

Full Name:	Employer Name:	Date:

Rates:

Employee/Spouse Supplemental Life and AD&D

Age	Employee Rate per $1,000	Spouse Rate* per $1,000
0-29	$0.115	$0.115
30-34	$0.125	$0.125
35-39	$0.155	$0.155
40-44	$0.215	$0.215
45-49	$0.325	$0.325
50-54	$0.575	$0.575
55-59	$0.875	$0.875
60-64	$1.015	$1.015
65-69	$1.795	$1.795
70-74	$3.475	N/A
75-79	$9.305	N/A
80+	$21.065	N/A

To calculate your Employee Supplemental Life premium:

_____ / $1,000 = _____ x _____ = $_____
Coverage Amount — Rate (See chart) — Monthly Premium

To calculate your Spouse Supplemental Life* premium:

_____ / $1,000 = _____ x _____ = $_____
Coverage Amount — Rate (See chart) — Monthly Premium

**Rates for Spouse Supplemental Life are based on the Spouse's age*

Dependent Child Supplemental Life Premium: $2.00 per month

Lincoln Financial Group®

The Lincoln National Life Insurance Company
P.O. Box 2616, Omaha, NE 68103-2616
Phone: (800) 423-2765 Fax: (877) 573-6177

ENROLLMENT FORM FOR GROUP INSURANCE

Please Use Ink or Type	GROUP ID: **TOWNOFMORE**	GROUP POLICY #: 010215461	Billing Division or Location: 1560790

A. Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name (Please Print) Town of Moretown			County	Employer ZIP	State
Employee Last Name	First Name	Middle Initial	Social Security Number		Date of Birth
Street Address			City	State	Zip
Gender: ☐Male ☐Female	Marital Status: ☐Married ☐Single		Home Phone ( )		Work Phone ( )

Completed By Employer

Average Hours Worked Per Week:	Occupation:	
Earnings: ☐ Hourly ☐ Monthly ☐ Weekly ☐ Yearly $_____	Date of Full-Time Employment:	Rehire Date:

B. Product Selection (Complete for ALL Enrollments)

Basic Coverage NOTE: Please mark the box or boxes for each coverage you are applying for. All coverage amounts are subject to the limitations and exclusions as stated in the policy.

Class	Effective Date	Type of Coverage	Amount of Coverage	Total Premium
		Short Term Disability ☒Yes ☐No	$	Employer Paid

E. Request for Coverages

This coverage has been offered to me and after careful consideration of the benefits, I have decided to:

☐ **REQUEST COVERAGE for which I am or may become eligible under the group policies issued by The Lincoln National Life Insurance Company.** I hereby apply for group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary.

☐ **NOT ENROLL myself in the Program.** I understand that if I apply for coverage at a later date, and if a physical examination or further medical information is required, it will be at my own expense.

☐ **NOT ENROLL my dependents in the Program.** I understand that if I apply for coverage for my dependents at a later date, and if a physical examination or further medical information is required, it will be at my own expense.

NOTE: A PERSON COMMITS INSURANCE FRAUD, IF HE OR SHE SUBMITS AN APPLICATION OR CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT WITH INTENT TO DEFRAUD (OR KNOWING THAT HE OR SHE IS HELPING TO DEFRAUD) AN INSURANCE COMPANY.

The insurance requested on this enrollment form will not be effective until approved by the Group Insurance Service Office of The Lincoln National Life Insurance Company, and the initial premium is paid to The Lincoln National Life Insurance Company. A delayed effective date will apply if the employee is not actively at work, or a dependent is in a period of limited activity on the date insurance would otherwise take effect.

Employee Full Name:_____ Employee Signature:_____ Date:_____

Lincoln Financial Group℠

The Lincoln National Life Insurance Company, PO Box 2649, Omaha, NE 68103-2649
toll free (800) 423-2765 Fax (800) 462-4660
www.LincolnFinancial.com

BENEFICIARY DESIGNATION FORM

Policyholder/Employer	Policy Number(s)
Employee Name	Employee Social Security or Certificate Number
Employee Address (Street, City, State)	Employee Telephone Number

WHO ARE YOUR BENEFICIARIES?

It is very important to clearly indicate your primary beneficiary(ies) and contingent beneficiary(ies). Proceeds are paid to contingent beneficiary(ies) only if there is no surviving primary beneficiary(ies). If multiple primary beneficiaries or contingent beneficiaries are named and no percentage distribution is noted, then any proceeds payable to such beneficiaries will be split equally. If more space is needed to list your beneficiaries please attach a sheet to this form. **The beneficiary(ies) named on this form will be valid for all basic, optional, and/or voluntary group term life and AD&D coverages unless otherwise indicated by you. The beneficiary designation may not go into effect until this form is signed and dated by you. Page 2 of this form includes examples of how to complete this form.**

PRIMARY BENEFICIARY(IES)

Primary Beneficiary's Name and Address	Social Security Number	Relationship to You	Date of Birth	Percentage: Must equal 100%
Name: Address:				
Name: Address:				
Name: Address:				

CONTINGENT BENEFICIARY(IES): Contingent beneficiaries will only receive benefit if there are no surviving primary beneficiaries.

Contingent Beneficiary's Name and Address	Social Security Number	Relationship to You	Date of Birth	Percentage: Must equal 100%
Name: Address:				
Name: Address:				
Name: Address:				

Community Property State Consent for residents of Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, or Wisconsin. If you are married, live in a community property state, and name someone other than your spouse as beneficiary, you may have your spouse sign below to waive his or her rights to any community property interest in the benefit.

As the Insured's spouse, I do hereby consent to the beneficiary designation(s) indicated on this form and waive any rights that I may have to the proceeds of such insurance under applicable community property laws.

Signature of Spouse _____ Date _____

Signature of Employee _____ **Date** _____

COMPLETING YOUR BENEFICIARY DESIGNATION FORM

1. At the top of the form, fill in the information regarding your employer and yourself.
2. Next complete the information regarding who will be your primary and contingent beneficiaries. A primary beneficiary will be the person/people that you want to receive the life insurance benefit. The contingent beneficiary or beneficiaries will only receive the life insurance benefit if the primary beneficiary(ies) is no longer living. Indicate the percentage of the benefit amount that the beneficiary will receive. Do not use dollar amounts. Percentages must add up to 100%.
3. If you live in a community property state, are married and naming someone other than your spouse as the primary beneficiary, you should have your spouse sign this form to avoid any delays at claim time.
4. Sign and date the form.

Below is an example of how to complete the beneficiary designations:

PRIMARY BENEFICIARY(IES)

Primary Beneficiary's Name and Address	Social Security Number	Relationship to You	Date of Birth	Percentage: Must equal 100%
Name: Jill Doe Address: 123 Main St, Anytown, NE 00000	XXX-XX-XXXX	Wife	XX/XX/XX	100%
Name: Address:				
Name: Address:				

CONTINGENT BENEFICIARY(IES): Contingent beneficiaries will only receive benefit if there are no surviving primary beneficiaries.

Contingent Beneficiary's Name and Address	Social Security Number	Relationship to You	Date of Birth	Percentage: Must equal 100%
Name: John Doe Sr Address: 456 Main Ln, Anytown, NE 00000	XXX-XX-XXXX	Father	XX/XX/XX	50%
Name: Mary Doe Address: 789 Main Rd, Anytown, NE 00000	XXX-XX-XXXX	Sister	XX/XX/XX	25%
Name: Jack Doe Irrevocable Trust, Jill Doe TTEE UTA 1/04 Address: 123 Main St, Anytown, NE 00000	XXX-XX-XXXX	Trust		25%

FREQUENTLY ASKED QUESTIONS

Should I name a minor child as a beneficiary?
You may name a minor child as a beneficiary, however please be aware that we cannot make payment of a claim directly to a minor. If a claim is incurred we would need to make payment via UTMA or to the guardian of the minor's financial estate. Or, if guardianship is not obtained and if UTMA does not apply, the benefit will be placed On Hold - Age of Majority and payable once the minor reaches the age of majority.

How would I name a Charitable Organization as a beneficiary?
A charitable organization that is not your employer may be named as a beneficiary. You will need to indicate the name of the charitable organization, a contact for the organization, their tax identification number, and the percentage of the benefit that would be payable to them.

How do I name my Estate as the beneficiary?
You may name your estate as a beneficiary. To name your estate as the beneficiary indicate "My Estate" as the beneficiary. If you know who will be the executor or administrator of your estate you should also include that person's name. For example: My Estate, John Doe Executor.

How do I name a Trust as the beneficiary?
You may designate a trust as a beneficiary. To name a trust as a beneficiary, indicate Trustee (show Name and address) under Trust Agreement Dated (show date). If the trust has a tax identification number that will need to be supplied in place of the social security number. For example: Jack Doe Irrevocable Trust, Jill Doe TTEE UTA 1/1/04.

VERMONT MUNICIPAL EMPLOYEE'S RETIREMENT SYSTEM
NOTIFICATION OF EMPLOYMENT

109 State St, 4th Fl · Montpelier, VT 05609 · Phone (802) 828-2305 · Fax (802-828-5182)

This form shall be completed and forwarded to this office **at time of employment** for any person to be regularly employed as follows: 24 or more hours per week and 1040 hours a year for any calendar scheduled employee, or 30 or more hours per week and 1040 hours a year for any school year scheduled employee. PLEASE PRINT OR TYPE INFORMATION BELOW:

EMPLOYEE INFORMATION

Date of Birth Mo Day Yr	**Male ( ) Female ( )**	Marital Status (Optional) Single Married Divorced Widowed Widower Civil Union
Last Name		
First Name	**M.I.**	
Address		Social Security Number - -
Town/City	**State** **Zip**	Phone number: Email:

I certify the above information to be complete and accurate to the best of my knowledge and belief. **I understand that I must participate in the Vermont Municipal Employees' Retirement System, as participation is a condition of my employment.** I hereby consent and agree to deductions for that purpose and understand that the full amount of deduction from my compensation, with allowable interest thereon, will be returned to me if I leave service without a retirement benefit or will be paid to my beneficiary if I die before qualifying for such a benefit.

Date _____ Signature (Employee) _____

EMPLOYER INFORMATION

Name and Phone # of Employer (Payroll Unit) (802)	Payroll Unit #:	Date of Hire:
Employees Position or Title	Projected Annual or Contracted Salary: MUST BE ENTERED $	
What Group(s) Will the New Hire Be Eligible for? GROUP A _____ GROUP B _____ GROUP C _____ GROUP D _____ DEFINED CONTRIBUTION _____	Type of Year Worked: Calendar Year (All year round): _____ School Year: _____	

PAYROLL OFFICER TO COMPLETE AND RETURN TO RETIREMENT SYSTEM UPON TERMINATION OF SERVICE

This is to certify that _____ terminated service
(Name of Employee)

with the _____ effective _____
(Name of Employer) (Date)

Date _____ Signed (Payroll Officer) _____