## **Bloom Carroll Local Schools**

	INFORMATION:								
Location	Hire Date	Date Waitin	g Period Began	Effe	ctive Date	Network	Basic Life/AD&D	Supp. Life	LTD
	/ /20	,	/20	,	/20		¢.	ć	¢
	/ /20	/	/20	/	/20		\$ -	\$ -	\$ -
Application is fo	or: 🛛 🗆 New Enrol	mont	Enrollment Ch	ange (if chan	te check helow)				
Application is to		intent			ge, check below)				
□Add Spouse	□Add Child(ren) □Dro	p Spouse 🛛 🛛	Drop Child(ren)	□Change Na	ame 🗆 Change A	Address			
B. EMPLOYEE I	NFORMATION:								
Last Name		First Name / M	1	Sex	Date of Birth	Socia	l Security #	Phone #	
				□Male	Mo/Day/Yr	-	-		
Church Address		Chu		□Female	/ /	<b>F</b>			
Street Address		City		State	Zip Code	E-mail Address	•		
C. DEPENDENT	INFORMATION: (List all dep	endents to be co	overed under your	chosen plan		ł			
	Last Name	First N	ame / MI	M/F	Date of Birth	Socia	l Security #	Relationship	Add/Drop
					1 1				
					/ /	-	-		
					/ /	-	-		
					/ /	_	_		
					/ /	-	-		
					/ /	-	-		
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					/ /	-		1	
					/ /	-	-		
D. PLAN OPTIO	ONS: (Please select your plan)	s)					r		
Medical Plan(s)	Enrollment		Dental Plan		Enrollment				
Choose One									
□Bloom Carrol □Bronze Plan		niy			Enrollee Only				
	□Family		□Waive		□Family				
□Waive									
Supp. Life/Employee					ife/Spouse		S	upp. Life/Child(ren)	
□Elect □Elect							Elect		
□Waive	\$		□Waive	\$			□Waive	\$	
E. OTHER COVE	ERAGE INFORMATION:								
	se or any dependent have oth	or boalth incura	202	□Yes □No	If yes, pro	ovido:			□Medical
Does your spou	se of any dependent have oth		ice:		ii yes, pii	ovide.		Coverage Type	
Name(s) of Cove	arad Barcon(s)					Effective Date	/ /		
								_	
Employer				Address				Phone#	
Employer	Name			Address				Phone#	
	Name								
Employer Claims Payor	Name			Address Address				Phone# Phone#	
Employer Claims Payor	Name								
Employer Claims Payor F. LIFE/AD&D E	Name Name Name BENEFICIARY INFORMATION:	neficiary(ies)		Address	iciary/ies) is not livi	ng at your death	) henefits are to be	Phone#	
Employer Claims Payor F. LIFE/AD&D E	Name	neficiary(ies):		Address	iciary(ies) is not livit	ng at your death	1, benefits are to be p	Phone#	
Employer Claims Payor F. LIFE/AD&D E	Name Name Name BENEFICIARY INFORMATION:	neficiary(ies): Relationship	% of Benefits	Address	iciary(ies) is not livi	ng at your death	n, benefits are to be p	Phone#	
Employer Claims Payor F. LIFE/AD&D E Your Death Ben	Name Name Name BENEFICIARY INFORMATION:		% of Benefits	Address If First Benef	iciary(ies) is not livi	ng at your death	n, benefits are to be p	Phone#	eneficiary(ies)
Employer Claims Payor F. LIFE/AD&D E Your Death Ben Name	Name Name Name BENEFICIARY INFORMATION:		% of Benefits	Address If First Benef	iciary(ies) is not livi	ng at your death	n, benefits are to be p	Phone#	eneficiary(ies)
Employer Claims Payor F. LIFE/AD&D E Your Death Ben	Name Name Name BENEFICIARY INFORMATION:		% of Benefits	Address If First Benef	iciary(ies) is not livi	ng at your death	n, benefits are to be p	Phone#	eneficiary(ies)
Employer Claims Payor F. LIFE/AD&D E Your Death Ben Name ACCEPTANCE:	Name Name Name BENEFICIARY INFORMATION:	Relationship		Address If First Benef Name				Phone#	eneficiary(ies) % of Benefits
Employer Claims Payor F. LIFE/AD&D E Your Death Ben Name ACCEPTANCE: I hereby apply for entitled. I unders	Name Name BENEFICIARY INFORMATION: efits are to be paid to First Be efits are to be paid to First Be	Relationship r may become elig	ible as elected above	Address If First Benef Name e. Lauthorize d	eductions, if any, from	n my compensatio	on for my share of the d	Phone#	eneficiary(ies) % of Benefits to which I become
Employer Claims Payor F. LIFE/AD&D E Your Death Ben Name ACCEPTANCE: I hereby apply for entitled. I unders	Name Name BENEFICIARY INFORMATION: efits are to be paid to First Be	Relationship r may become elig	ible as elected above	Address If First Benef Name e. Lauthorize d	eductions, if any, from	n my compensatio	on for my share of the d	Phone#	eneficiary(ies) % of Benefits to which I become
Employer Claims Payor F. LIFE/AD&D E Your Death Ben Name ACCEPTANCE: I hereby apply for entitled. I unders contained herein	Name Name BENEFICIARY INFORMATION: efits are to be paid to First Be group coverage for which I am o itand that I must meet the eligibil is correct and true.	Relationship r may become elig	ible as elected above f the Plan and that th	Address If First Benef Name . Lauthorize d he completion of	eductions, if any, from	n my compensatio m does not guara	on for my share of the ntee coverage under th	Phone#	eneficiary(ies) % of Benefits to which I become he information
Employer Claims Payor F. LIFE/AD&D E Your Death Ben Name ACCEPTANCE: I hereby apply for entitled. I unders contained herein I elect to have my	Name Name BENEFICIARY INFORMATION: efits are to be paid to First Be group coverage for which I am o tand that I must meet the eligibil is correct and true. contribution to the cost of such	Relationship r may become elig ity requirements o	ible as elected above f the Plan and that th f from my pay on a p	Address If First Benef Name e. I authorize d he completion re-tax basis. I	eductions, if any, from of this enrollment for understand that the c	n my compensati m does not guara ost to me for cove	on for my share of the on the on the one of the one one of the one	Phone#	eneficiary(ies) % of Benefits to which I become he information
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