Bloom Carroll Local Schools

A. EMPLOYER INFORMATION:

Location	Hire Date	Start Date	Effective Date		Basic Life/AD&D Employee	Supp. Life Employee	Supp ADAD Employee
	/ /20	/ /20	/ /20		$	$	$

Application is for: ☐New Enrollment ☐ Enrollment Change (if change, check below) ☐ Termination Reason:_____

☐Add Spouse ☐Add Child(ren) ☐Drop Spouse ☐Drop Child(ren) ☐Change Name ☐Change Address

B. EMPLOYEE INFORMATION:

Last Name	First Name / MI	Sex	Date of Birth	Social Security #	Phone #
		☐Male ☐Female	Mo/Day/Yr / /	- -	

Street Address	City	State	Zip Code	E-mail Address

C. DEPENDENT INFORMATION: (List all dependents to be covered under your chosen plan)

Last Name	First Name / MI	M/F	Date of Birth	Social Security #	Relationship	Add/Drop
			/ /	- -		
			/ /	- -		
			/ /	- -		
			/ /	- -		
			/ /	- -		
			/ /	- -		

D. PLAN OPTIONS: (Please select your plan(s)

Medical Plan(s) Choose One	Enrollment	Dental Plan	Enrollment	Vision Plan	Enrollment
☐Bloom Carroll	☐Enrollee Only	☐Elect	☐Enrollee Only	☐Elect	☐Enrollee Only
☐Bronze Plan	☐Family	☐Waive	☐Family	☐Waive	☐Family
☐Waive					

Supp. ADAD (must elect Supp Life)/Spouse
☐Elect
☐Waive $

Supp. Life/Spouse	Supp. Life/Child(ren)	Supp. ADAD (must elect Supp Life)/Child(ren)
☐Elect ☐Waive $	☐Elect ☐Waive $	☐Elect ☐Waive $

E. OTHER COVERAGE INFORMATION: ***If you are adding a spouse or child(ren) to the plan this section MUST be completed.***

Does your spouse or any dependent have other health insurance? ☐Yes ☐No If yes, provide: Coverage Type ☐Medical ☐Dental ☐Vision

Name(s) of Covered Person(s) _____ Effective Date ___/___/___

Employer _____
Name Address Phone#

Claims Payor _____
Name Address Phone#

F. LIFE/AD&D BENEFICIARY INFORMATION:

Your Death Benefits are to be paid to First Beneficiary(ies):

Name	Relationship	% of Benefits

If First Beneficiary(ies) is not living at your death, benefits are to be paid to Secondary Beneficiary(ies)

Name	Relationship	% of Benefits

ACCEPTANCE:

I hereby apply for group coverage for which I am or may become eligible as elected above. I authorize deductions, if any, from my compensation for my share of the cost of the coverages to which I become entitled. I understand that I must meet the eligibility requirements of the Plan and that the completion of this enrollment form does not guarantee coverage under the Plan. I affirm that the information contained herein is correct and true.

I elect to have my contribution to the cost of such coverage deducted from my pay on a pre-tax basis. I understand that the cost to me for coverage will be deducted from my gross earnings prior to calculation of certain taxes to be withheld each pay period. I also understand that I may not make any changes in my pre-tax election until the next pre-tax open enrollment period. However, I understand that an election change is permitted due to significant cost or coverage changes to me or a change in my family status as outlined in the Summary Plan Description.

Employee Signature _____ Date _____

DECLINATION:

I hereby decline medical coverage under my employer's medical plan for myself ☐ and/or my dependents ☐ I understand I may not be able to enroll until the next Open Enrollment Period or within 30 days of an event that qualifies as a "Special Enrollment" event.

Employee Signature _____ Date _____

PRE-TAX CONTRIBUTION DECLINATION:

Check and sign this box ***only*** *if you want your contributions to be subject to payroll taxes*

☐ I do not wish to have my share of the cost, for the coverages I have elected to be deducted from my pay on a pre-tax basis.

Employee Signature _____ Date _____