Bloom-Carroll Local Schools Insurance Enrollment Form Completion

Please complete the form on the next page as follows:

Section A

Payroll will complete the location and dates section.

Complete the *Application is for:* (check the appropriate box) section.

If you are only changing your name or address, you can complete section B and skip the remaining sections. Then sign under acceptance.

If you are completing a new enrollment, enrollment change or terminating any coverage, please complete the entire form.

Section B

Complete all information in this section.

Section C

Complete the information for each dependent that you want covered. Please be sure to include all information as it is required to enroll each dependent. The form will be sent back to you if this section is not complete.

Section D

Select the coverage that you want. You are not required to take all or none. For example, you can elect medical but not dental or vision or you can elect family medical and enrollee only vision, etc. Select Bloom Carroll (the Bronze Plan is not an option we use). If you are not electing that coverage type, please check the *waive* box.

Life Insurance: The school board provides you with a life insurance policy of \$40,000 that is board paid. You will see this on your pay notification at a cost of \$1.90 per pay. It will have an * beside the cost. All items on your pay notification that have an * is a board paid amount. If you wish to elect additional life insurance coverage, you can elect that coverage at an additional cost to you. The information and cost for this can be found on the District website under Forms/Employee Benefit Notices and Forms/Additional Life Insurance Form.

The sections listed as Supp. ADAD/Spouse and Supp. ADAD/Child(ren) are elections to select if you want to purchase additional life insurance for your spouse or child(ren). You can only select these options if you elect additional life insurance for yourself. Please let Payroll/Benefits know that you are electing additional coverage and in what amount.

Section E

Complete this section regarding any other insurance coverage for your spouse or child(ren).

Section F

Complete this section to list your beneficiary(ies).

Sign and date the Acceptance section stating that you are electing coverage OR Sign and date the Declination section if you are not electing coverage .

Please ignore the Pre-Tax Contribution Section as this is not offered at Bloom-Carroll

When submitting this form and any required documentation to the Payroll/Benefits department, please communicate your intentions for coverage so a verification can be made that the form is completed correctly.

Bloom Carroll Local Schools

A. EMPLOYER II	NFORMATION:								
							Basic Life/AD&D	Supp. Life	Supp ADAD
Location	Hire Date	Stai	rt Date	Effe	ctive Date		Employee	Employee	Employee
	/ /20	/	/20	/	/20		\$	\$	\$
•				•	•	!	* '		•
Application is for	r: New Enroll	ment	☐ Enrollment Ch	ange (if chan	ge, check below)		☐ Termination Rea	son:	
□Add Spouse	□Add Child(ren) □Dro	p Spouse □I	Orop Child(ren)	□Change N	ame Change	Address			
B. EMPLOYEE IN	NFORMATION:								
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 Addres	s	<u> </u>	
C DEDENIDENT	INFORMATION: (List all depo	andonts to be so	word under vour	chasan nlan					
Last Name		First Name / MI		M/F	Date of Birth	Soci	Social Security # Relationship Add/		Add/Drop
					, ,		-		•
					/ /	-	-		
					/ /	-	-		
					/ /	-	-		
					, ,				
					/ /	-	-		
					/ /	-	-		
					/ /	_	-		
D. PLAN OPTIO	NS: (Please select your plan(s)				!			
Medical Plan(s)	Enrollment		Dental Plan		Enrollment		Vision Plan	Enrollment	
Choose One ☐Bloom Carroll	□Enrolloo O	alv	□Elect		□Enrollee Only		□Elect □Waive	□Enrollee Only □Family	
□Bronze Plan	□Enrollee Oi □Family	пу	□Waive		□Enrollee Only □Family		Supp. ADAD (must e	· · · · · · · · · · · · · · · · · · ·	NISA
□Waive	шт аттту		waive		штапшу		□Elect	cicci supp Life,/ spe	Juse
							□Waive	\$	
	Supp. Life/Spouse			Supp. Li	e/Child(ren)		Supp. ADAD (must e	elect Supp Life)/Chi	ld(ren)
				•		□Elect □ Maive			
□Elect	r		□Elect	c				ď	
□Waive	\$		□Waive	\$			□Waive	\$	
□Waive	\$ RAGE INFORMATION: <i>If you</i>	ı are adding a	□Waive	d(ren) to th	e plan this secti	on MUST be	□Waive	\$	
E. OTHER COVE	RAGE INFORMATION: <i>If you</i>		□Waive spouse or child	d(ren) to th	•		□Waive	•	□Medical
E. OTHER COVE	<u> </u>		□Waive spouse or child	d(ren) to th	e plan this secti If yes, pr		□Waive	\$ Coverage Type	□Medical □Dental
E. OTHER COVE	RAGE INFORMATION: If you see or any dependent have oth		□Waive spouse or child	d(ren) to th	•		□Waive completed.	•	
E. OTHER COVE Does your spous Name(s) of Cove	RAGE INFORMATION: If you see or any dependent have oth		□Waive spouse or child	d(ren) to th	•	ovide:	□Waive completed.	•	□Dental
■ Waive E. OTHER COVE Does your spous	RAGE INFORMATION: If you see or any dependent have oth		□Waive spouse or child	d(ren) to th	•	ovide:	□Waive completed.	•	□Dental
E. OTHER COVE Does your spous Name(s) of Cove	RAGE INFORMATION: If you see or any dependent have othered Person(s)		□Waive spouse or child	d(ren) to th ☐Yes ☐No	•	ovide:	□Waive completed.	Coverage Type	□Dental
E. OTHER COVE Does your spous Name(s) of Cove Employer	RAGE INFORMATION: If you see or any dependent have othered Person(s)		□Waive spouse or child	d(ren) to th ☐Yes ☐No	•	ovide:	□Waive completed.	Coverage Type	□Dental
E. OTHER COVE Does your spous Name(s) of Cove Employer Claims Payor	RAGE INFORMATION: If you see or any dependent have othered Person(s) Name		□Waive spouse or child	d(ren) to the Second Sec	•	ovide:	□Waive completed.	Coverage Type - Phone#	□Dental
E. OTHER COVE Does your spous Name(s) of Cove Employer Claims Payor F. LIFE/AD&D B	RAGE INFORMATION: If you see or any dependent have othered Person(s) Name Name ENEFICIARY INFORMATION:	er health insurai	□Waive spouse or child	d(ren) to the Pyes No	If yes, pr	ovide: Effective Date	□Waive completed.	Coverage Type Phone#	□Dental □Vision
E. OTHER COVE Does your spous Name(s) of Cove Employer Claims Payor F. LIFE/AD&D B	RAGE INFORMATION: If you see or any dependent have othered Person(s) Name	er health insurai	□Waive spouse or child	d(ren) to the Pyes No	If yes, pr	ovide: Effective Date	□Waive completed.	Coverage Type Phone#	□Dental □Vision
E. OTHER COVE Does your spous Name(s) of Cove Employer Claims Payor F. LIFE/AD&D B	RAGE INFORMATION: If you see or any dependent have othered Person(s) Name Name ENEFICIARY INFORMATION:	er health insurai	□Waive spouse or child	d(ren) to the Pyes No	If yes, pr	ovide: Effective Date	□Waive completed.	Coverage Type Phone#	□Dental □Vision
E. OTHER COVE Does your spous Name(s) of Cove Employer Claims Payor F. LIFE/AD&D B Your Death Benefit	RAGE INFORMATION: If you see or any dependent have othered Person(s) Name Name ENEFICIARY INFORMATION:	er health insurai	spouse or child	Address Address If First Benefit	If yes, pr	ovide: Effective Date	□Waive completed.	Coverage Type Phone# Phone#	□Dental □Vision eneficiary(ies)
E. OTHER COVE Does your spous Name(s) of Cove Employer Claims Payor F. LIFE/AD&D B Your Death Beneral	RAGE INFORMATION: If you see or any dependent have othered Person(s) Name Name ENEFICIARY INFORMATION:	er health insurai	spouse or child	Address Address If First Benefit	If yes, pr	ovide: Effective Date	□Waive completed.	Coverage Type Phone# Phone#	□Dental □Vision eneficiary(ies)
E. OTHER COVE Does your spous Name(s) of Cove Employer Claims Payor F. LIFE/AD&D B Your Death Bene Name	RAGE INFORMATION: If you see or any dependent have othered Person(s) Name Name ENEFICIARY INFORMATION: efits are to be paid to First Bei	neficiary(ies):	% of Benefits	Address Address If First Benef	If yes, pr	ovide: Effective Date	□Waive completed. e / / h, benefits are to be p	Coverage Type Phone# Phone# Daid to Secondary Be Relationship	□Dental □Vision eneficiary(ies) % of Benefits
E. OTHER COVE Does your spous Name(s) of Cove Employer Claims Payor F. LIFE/AD&D B Your Death Benee Name ACCEPTANCE: I hereby apply for	RAGE INFORMATION: If you see or any dependent have othered Person(s) Name Name ENEFICIARY INFORMATION:	neficiary(ies): Relationship	% of Benefits	Address Address If First Benefinate.	If yes, pr	ovide: Effective Date ng at your deat	DWaive completed. a / / h, benefits are to be placed in for my share of the completed.	Coverage Type Phone# Phone# Relationship cost of the coverages t	□Dental □Vision eneficiary(ies) % of Benefits o which I become
E. OTHER COVE Does your spous Name(s) of Cove Employer Claims Payor F. LIFE/AD&D B Your Death Bene Name ACCEPTANCE: I hereby apply for entitled. I underst	RAGE INFORMATION: If you see or any dependent have othered Person(s) Name Name ENEFICIARY INFORMATION: Best to be paid to First Best to be paid	neficiary(ies): Relationship	% of Benefits	Address Address If First Benefinate.	If yes, pr	ovide: Effective Date ng at your deat	DWaive completed. a / / h, benefits are to be placed in for my share of the completed.	Coverage Type Phone# Phone# Relationship cost of the coverages t	□Dental □Vision eneficiary(ies) % of Benefits o which I become
E. OTHER COVE Does your spous Name(s) of Cove Employer Claims Payor F. LIFE/AD&D B Your Death Bene Name ACCEPTANCE: I hereby apply for entitled. I underst contained herein is	RAGE INFORMATION: If you see or any dependent have othered Person(s) Name Name ENEFICIARY INFORMATION: efits are to be paid to First Bereits are to be pai	neficiary(ies): Relationship r may become elig	% of Benefits tible as elected above f the Plan and that the	Address Address If First Benefit Name L. Lauthorize one completion	iciary(ies) is not livi	ovide: Effective Date ng at your deat m my compensat m does not guara	h, benefits are to be particle for my share of the cantee coverage under the	Coverage Type Phone# Phone# Relationship cost of the coverages to the Phane I affirm that the phane I affirm the phane I	eneficiary(ies) % of Benefits o which I become information
E. OTHER COVE Does your spous Name(s) of Cove Employer Claims Payor F. LIFE/AD&D B Your Death Bene Name ACCEPTANCE: I hereby apply for entitled. I underst contained herein is	RAGE INFORMATION: If you see or any dependent have othered Person(s) Name Name ENEFICIARY INFORMATION: Efits are to be paid to First Bereits are to be pai	neficiary(ies): Relationship r may become elig ty requirements o	% of Benefits ible as elected above f the Plan and that the difference of the property of the	Address Address Address If First Benefinate Control of the Completion are-tax basis. I	iciary(ies) is not livi	ng at your deat	h, benefits are to be particle coverage under the coverage will be deducted to	Coverage Type Phone# Phone# Relationship cost of the coverages to a Plan. I affirm that the phone in the	eneficiary(ies) % of Benefits o which I become the information
E. OTHER COVE Does your spous Name(s) of Cove Employer Claims Payor F. LIFE/AD&D B Your Death Benee Name ACCEPTANCE: I hereby apply for entitled. I underst contained herein is I elect to have my calculation of certains	RAGE INFORMATION: If you see or any dependent have othered Person(s) Name Name ENEFICIARY INFORMATION: effits are to be paid to First Bereits are to be pa	neficiary(ies): Relationship r may become elig ty requirements o	% of Benefits the Plan and that the plan and that the plan and that I may independ the plan and	Address Address Address If First Benefine completion are-tax basis. I not make any complete and complete	iciary(ies) is not livieductions, if any, from for this enrollment for understand that the changes in my pre-tax	ng at your deat m my compensat m does not guara	h, benefits are to be particle of the control of th	Coverage Type Phone# Phone# Relationship cost of the coverages to a Plan. I affirm that the phone in the	eneficiary(ies) % of Benefits o which I become the information
E. OTHER COVE Does your spous Name(s) of Cove Employer Claims Payor F. LIFE/AD&D B Your Death Benee Name ACCEPTANCE: I hereby apply for entitled. I underst contained herein is I elect to have my calculation of certains	RAGE INFORMATION: If you see or any dependent have othered Person(s) Name Name ENEFICIARY INFORMATION: efits are to be paid to First Bereits are to be withheld each pay an ange is permitted due to signific	neficiary(ies): Relationship r may become elig ty requirements o	% of Benefits the Plan and that the plan and that I may independent to the plan and the plan an	Address Address Address If First Benefine completion are-tax basis. I not make any complete and complete	iciary(ies) is not livieductions, if any, from for this enrollment for understand that the changes in my pre-tax	ng at your deat m my compensat m does not guara	h, benefits are to be particle of the control of th	Coverage Type Phone# Phone# Relationship cost of the coverages to a Plan. I affirm that the phone in the	eneficiary(ies) % of Benefits o which I become the information
E. OTHER COVE Does your spous Name(s) of Cove Employer Claims Payor F. LIFE/AD&D B Your Death Bene Name ACCEPTANCE: I hereby apply for entitled. I underst contained herein is I elect to have my calculation of certa that an election chemployee Signate	RAGE INFORMATION: If you see or any dependent have othered Person(s) Name Name ENEFICIARY INFORMATION: efits are to be paid to First Bereits are to be withheld each pay an ange is permitted due to signific	neficiary(ies): Relationship r may become elig ty requirements o	% of Benefits the Plan and that the plan and that I may independent to the plan and the plan an	Address Address Address If First Benefine completion are-tax basis. I not make any complete and complete	iciary(ies) is not livieductions, if any, from for this enrollment for understand that the changes in my pre-tax	ng at your deat m my compensat m does not guara	h, benefits are to be particle coverage will be deducted in eart pre-tax open enrollary Plan Description.	Coverage Type Phone# Phone# Relationship cost of the coverages to a Plan. I affirm that the phone in the	eneficiary(ies) % of Benefits o which I become the information
E. OTHER COVE Does your spous Name(s) of Cove Employer Claims Payor F. LIFE/AD&D B Your Death Bene Name ACCEPTANCE: I hereby apply for entitled. I underst contained herein is contained herein is left. I underst contained herein is left. I	RAGE INFORMATION: If you see or any dependent have othered Person(s) Name Name ENEFICIARY INFORMATION: efits are to be paid to First Belling are to be pai	neficiary(ies): Relationship r may become elig ty requirements o	% of Benefits ible as elected above f the Plan and that the plan and th	Address Address Address If First Benef Name a. I authorize cone completion are-tax basis. I not make any cone change in minusers	iciary(ies) is not livi eductions, if any, fror of this enrollment for understand that the changes in my pre-tax of family status as outl	n my compensat m does not guara	ion for my share of the cantee coverage under the rerage will be deducted in next pre-tax open enrol hary Plan Description. Date	Coverage Type Phone# Phone# Relationship cost of the coverages to e Plan. I affirm that the from my gross earning liment period. However	eneficiary(ies) % of Benefits o which I become ne information ss prior to er, I understand
E. OTHER COVE Does your spous Name(s) of Cove Employer Claims Payor F. LIFE/AD&D B Your Death Bene Name ACCEPTANCE: I hereby apply for entitled. I underst contained herein is I elect to have my calculation of cert that an election chemployee Signat DECLINATION: I hereby decline merein is the contained herein herei	RAGE INFORMATION: If you see or any dependent have othered Person(s) Name Name ENEFICIARY INFORMATION: efits are to be paid to First Bereits are to be withheld each pay an ange is permitted due to signific	neficiary(ies): Relationship r may become elig ty requirements o	% of Benefits ible as elected above f the Plan and that the plan and th	Address Address Address If First Benef Name a. I authorize cone completion are-tax basis. I not make any cone change in minusers	iciary(ies) is not livi eductions, if any, fror of this enrollment for understand that the changes in my pre-tax of family status as outl	n my compensat m does not guara	ion for my share of the cantee coverage under the rerage will be deducted in next pre-tax open enrol hary Plan Description. Date	Coverage Type Phone# Phone# Relationship cost of the coverages to e Plan. I affirm that the from my gross earning liment period. However	eneficiary(ies) % of Benefits o which I become ne information ss prior to er, I understand
E. OTHER COVE Does your spous Name(s) of Cove Employer Claims Payor F. LIFE/AD&D B Your Death Bene Name ACCEPTANCE: I hereby apply for entitled. I underst contained herein is I elect to have my calculation of cert that an election chemployee Signat DECLINATION: I hereby decline merein is the contained herein herei	RAGE INFORMATION: If you see or any dependent have othered Person(s) Name Name ENEFICIARY INFORMATION: effits are to be paid to First Belling and that I must meet the eligibility of the contribution to the cost of such a cain taxes to be withheld each pay ange is permitted due to significature medical coverage under my employualifies as a "Special Enrollment"	neficiary(ies): Relationship r may become elig ty requirements o	% of Benefits ible as elected above f the Plan and that the plan and th	Address Address Address If First Benef Name a. I authorize cone completion are-tax basis. I not make any cone change in minusers	iciary(ies) is not livi eductions, if any, fror of this enrollment for understand that the changes in my pre-tax of family status as outl	n my compensat m does not guara	maive completed. h, benefits are to be particular to be	Coverage Type Phone# Phone# Relationship cost of the coverages te Plan. I affirm that the priod. However the period of the p	eneficiary(ies) % of Benefits o which I become ne information ss prior to er, I understand
E. OTHER COVE Does your spous Name(s) of Cove Employer Claims Payor F. LIFE/AD&D B Your Death Bene Name ACCEPTANCE: I hereby apply for entitled. I underst contained herein is I elect to have my calculation of certain an election chemployee Signat DECLINATION: I hereby decline m of an event that que Employee Signat	RAGE INFORMATION: If you see or any dependent have othered Person(s) Name Name ENEFICIARY INFORMATION: efits are to be paid to First Benefits are to be withheld each pay an angle is permitted due to significature ledical coverage under my employualifies as a "Special Enrollment" ture	neficiary(ies): Relationship r may become elig ty requirements o	% of Benefits ible as elected above f the Plan and that the plan and th	Address Address Address If First Benef Name a. I authorize cone completion are-tax basis. I not make any cone change in minusers	iciary(ies) is not livi eductions, if any, fror of this enrollment for understand that the changes in my pre-tax of family status as outl	n my compensat m does not guara	ion for my share of the cantee coverage under the rerage will be deducted in next pre-tax open enrol hary Plan Description. Date	Coverage Type Phone# Phone# Relationship cost of the coverages te Plan. I affirm that the priod. However the period of the p	eneficiary(ies) % of Benefits o which I become ne information ss prior to er, I understand
E. OTHER COVE Does your spous Name(s) of Cove Employer Claims Payor F. LIFE/AD&D B Your Death Bene Name ACCEPTANCE: I hereby apply for entitled. I underst contained herein is I elect to have my calculation of certath an election chemployee Signate DECLINATION: I hereby decline m of an event that que mo of an event that que mo of an event that que mo of an event that que mployee Signate PRE-TAX CONTR	RAGE INFORMATION: If you see or any dependent have othered Person(s) Name Name ENEFICIARY INFORMATION: efits are to be paid to First Bendard that I must meet the eligibility of the correct and true. Contribution to the cost of such a language is permitted due to significature Literage and the eligibility of the cost of such a language is permitted due to significature Literage and the eligibility of the cost of such a language is permitted due to significature Literage and Enrollment" Literage and Enrollment and Enrol	neficiary(ies): Relationship r may become elig ty requirements o	% of Benefits ible as elected above f the Plan and that the derivative of the plan and that I may inge changes to me or	Address Address Address If First Benefine completion are-tax basis. I not make any can a change in minuser my depender	iciary(ies) is not livi eductions, if any, fror of this enrollment for understand that the changes in my pre-tax of family status as outl	n my compensat m does not guara	maive completed. h, benefits are to be particular to be	Coverage Type Phone# Phone# Relationship cost of the coverages te Plan. I affirm that the priod. However the period of the p	eneficiary(ies) % of Benefits o which I become ne information ss prior to er, I understand
E. OTHER COVE Does your spous Name(s) of Cove Employer Claims Payor F. LIFE/AD&D B Your Death Bene Name ACCEPTANCE: I hereby apply for entitled. I underst contained herein is I elect to have my calculation of certa that an election chemployee Signat DECLINATION: I hereby decline m of an event that que my fan event that	RAGE INFORMATION: If you see or any dependent have othered Person(s) Name Name ENEFICIARY INFORMATION: efits are to be paid to First Benefits are to be withheld each pay hange is permitted due to significature Hedical coverage under my employualifies as a "Special Enrollment" ture EIBUTION DECLINATION: his box only if you want your	r may become elig ty requirements o coverage deducted y period. I also unant cost or covera	% of Benefits ible as elected above f the Plan and that the derivation of the plan and that I may be derived the plan and that I may be derived from my pay on a property of the plan and that I may be derived from my pay on a property of the plan and that I may be derived from my pay on a property of the plan and that I may be derived from my pay on a property of the plan and the	Address Address Address If First Benefine completion are-tax basis. I not make any can a change in minus remarks and completion remarks and completion are completion are completion are completion.	iciary(ies) is not livi eductions, if any, fror of this enrollment for understand that the c hanges in my pre-tax family status as outl	ng at your deat may compensat m does not guara toest to me for covelection until the ined in the Summ may not be able t	maive completed. h, benefits are to be particular to be	Coverage Type Phone# Phone# Relationship cost of the coverages te Plan. I affirm that the priod. However the period of the p	eneficiary(ies) % of Benefits o which I become ne information ss prior to er, I understand
E. OTHER COVE Does your spous Name(s) of Cove Employer Claims Payor F. LIFE/AD&D B Your Death Bene Name ACCEPTANCE: I hereby apply for entitled. I underst contained herein is I elect to have my calculation of certa that an election che Employee Signat DECLINATION: I hereby decline m of an event that que Employee Signat PRE-TAX CONTR Check and sign to	RAGE INFORMATION: If you see or any dependent have othered Person(s) Name Name ENEFICIARY INFORMATION: effits are to be paid to First Bereits are to be withheld each payanage is permitted due to significature endical coverage under my employualifies as a "Special Enrollment" ture EIBUTION DECLINATION: this box only if you want your to have my share of the cost,	r may become elig ty requirements o coverage deducted y period. I also unant cost or covera	% of Benefits ible as elected above f the Plan and that the derivation of the plan and that I may be derived the plan and that I may be derived from my pay on a property of the plan and that I may be derived from my pay on a property of the plan and that I may be derived from my pay on a property of the plan and that I may be derived from my pay on a property of the plan and the	Address Address Address If First Benefine completion are-tax basis. I not make any can a change in minus remarks and completion remarks and completion are completion are completion are completion.	iciary(ies) is not livi eductions, if any, fror of this enrollment for understand that the c hanges in my pre-tax family status as outl	ng at your deat may compensat m does not guara toest to me for covelection until the ined in the Summ may not be able t	maive completed. h, benefits are to be particular to be	Coverage Type Phone# Phone# Relationship cost of the coverages te Plan. I affirm that the priod. However the period of the p	eneficiary(ies) % of Benefits o which I become ne information ss prior to er, I understand