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 each full-time (more than 20 hours/week) with a life insurance policy of \$40,000 that is board paid. You will see this on your pay notification at a cost of \$2.10 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 and your monthly premium will be deducted from your pay. You can find information about the coverage and calculating this additional cost on the District website under Forms/Payroll and Employee Benefit Notices/Forms/Additional Life Insurance Form. Please note that when you begin employment at Bloom-Carroll, you can elect up to the Guarantee Issue Maximum of \$100,000 for yourself and \$20,000 for your spouse without having to complete medical history paperwork. If you wish to request more than \$100,000 for yourself or \$20,000 for your spouse when you begin employment or you wish to request any additional amount more than 30 days from your first date of employment, you will be required to complete a medical history on each person requesting insurance. Please reach out to Payroll/Benefits to request this 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	Sta	rt Date	Effe	ective Date		Employee	Employee	Employee
	/ /20	/	/20	/	/20		\$	\$	\$
•							1 ·		•
Application is fo	r: New Enroll	ment	☐ Enrollment Ch	ange (if chan	ge, check below)		☐ Termination Rea	son:	
□Add Spouse	□Add Child(ren) □Dro	p Spouse □	Drop Child(ren)	□Change N	ame Change	Address			
B. EMPLOYEE IN	NFORMATION:								
Last Name		First Name / M	II .	Sex □Male	Date of Birth	Social Security #		Phone #	
				□Female	Mo/Day/Yr / /	-	-		
Street Address		City		State	Zip Code	E-mail Addres	s		
C. DEPENDENT	INFORMATION: (List all depo	endents to be co	overed under vour	chosen nlan)				
Last Name		First Name / MI		M/F	Date of Birth	Social Security # Relationship Add		Add/Drop	
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D. PLAN OPTIO Medical Plan(s)	NS: (Please select your plan) Enrollment	s)	Dental Plan		Enrollment		Vision Plan	Enrollment	
Choose One	Elifolilielit		Delitai Fiali		Elifolillelit		□Elect	□Enrollee Only	
□Bloom Carroll	I □Enrollee O	nly	□Elect		□Enrollee Only		□Waive	Family	
□Bronze Plan	□Family		□Waive		□Family		Supp. ADAD (must e	elect Supp Life)/Spc	ouse
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□Elect	Supp. Life/Spouse		Supp. Life/Child(ren) □Elect			Supp. ADAD (must elect Supp Life)/Child(ren) □Elect			
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