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.

For questions about this form, please contact Courtney Stebelton courtney.stebelton@bloomcarroll.org **x46704 740-756-9724**

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 _____