2015 TEACHERS BENEFITS ENROLLMENT & CHANGE FORM

Employee Information

Employee Last Name | First Name | M.I. | Date of Birth | Social Security Number

Street Address | City | State | Zip | County | Phone Number

Marital Status:

☐ Married ☐ Single

Gender:

☐ Male ☐ Female

Employee Elections

MEDICAL (Monthly Deduction Listed Below)

☐ **BCBSM Community Blue 1**

Single: $195.66 Two Person: $618.78 Family: $724.02

☐ **Waiver Medical Coverage:** Complete Waiver of Coverage on reverse side if waiving medical. *Please see reverse side if you maintain other health or dental insurance.*

DENTAL
BCBSM

☐ **Elect** ☐ **Waive**

VISION
NVA

☐ **Elect** ☐ **Waive**

Dependent Information

Full Name	Social Security Number	Gender	Birthdate	Medical	Dental	Vision
Spouse				☐Enroll ☐Term	☐Enroll ☐Term	☐Enroll ☐Term
Dep				☐Enroll ☐Term	☐Enroll ☐Term	☐Enroll ☐Term
Dep				☐Enroll ☐Term	☐Enroll ☐Term	☐Enroll ☐Term
Dep				☐Enroll ☐Term	☐Enroll ☐Term	☐Enroll ☐Term
Dep				☐Enroll ☐Term	☐Enroll ☐Term	☐Enroll ☐Term
Dep				☐Enroll ☐Term	☐Enroll ☐Term	☐Enroll ☐Term
Dep				☐Enroll ☐Term	☐Enroll ☐Term	☐Enroll ☐Term

I understand that the benefit elections I make now will remain in effect for the entire plan year and that I may not terminate or change them during the plan year unless I have a Change in Status Event and am eligible for a Special Enrollment Period. I understand that I am responsible for giving written notice to the Benefits Department within 30 days of changes in my status and/or my family's status that affect coverage, such as marriage, divorce, births, or deaths of anyone covered under my policy.

By signing this enrollment form, I acknowledge I have received a copy of the Summary of Benefits and Coverage (SBC) for the medical plan effective for the benefit plan year outlined above. Each year during the annual Open Enrollment period, I will have an opportunity to change my election. If I do not complete and return a new form at that time, this election will continue unchanged until I make a new election under the terms of the plan.

I understand that I need to contribute to the cost of these benefits and I authorize my employer to deduct the required Benefit Contributions, including any increases or decreases the Plan may require from those listed in the Benefit Guide, on a pre-tax basis from my earnings. I hereby certify that the statements herein are complete and accurate to the best of my knowledge. I understand benefits could be affected if I knowingly provide false, incomplete, or misleading information on this form.

EMPLOYEE SIGNATURE: ______________________________ DATE SIGNED: ______________

Supplemental Life

If interested in purchasing additional Life insurance please contact Anne Waldron.

Flexible Spending Account (FSA)

In order to participate in the Health Care FSA and/or Dependent Care FSA, you must complete a NGE Election Form. Please contact Anne Waldron for FSA packet.

Please return to Anna Waldron - sealed securely in an inner-office envelope by Thursday, December 4th.

2015 TEACHERS BENEFITS ENROLLMENT & CHANGE FORM

Other Insurance Coverage

Do you or your spouse or dependent(s) maintain other health coverage? ☐**No** ☐**Yes**
Do you or your spouse or dependent(s) maintain other dental coverage? ☐**No** ☐**Yes**

Type	**Name of Insured**	**Insurance Company Name, Phone Number, and Policy Number**	**Employer**

Life Insurance Beneficiary Form (Designation of Beneficiary)

Policy Holder: Garden City Public Schools	Policy Number(s): GL 675105
Insured Name	Social Security Number

I herby designate the following as my beneficiary(ies) under the above policy number(s):
Primary Beneficiary(ies)

Full Name and Address (Please Print)	Percentage* (must total 100%)	Date of Birth	Relationship	Social Security Number

*If no percentages are indicated, benefits will be divided equally between all primary beneficiaries.

Contingent Beneficiary(ies) (applicable only if you are not survived by one or more primary beneficiaries)

Full Name and Address (Please Print)	Percentage* (must total 100%)	Date of Birth	Relationship	Social Security Number

*If no percentages are indicated, any benefits payable to contingent beneficiaries will be divided equally between all contingent beneficiaries.

- This beneficiary designation revokes all revocable prior beneficiary designations.
- Unless you indicate otherwise, if any beneficiary predeceases you, that beneficiary's share will be divided pro-rated among the surviving beneficiaries of the same class (primary or contingent).
- If no beneficiary (primary or contingent) survives you, payment will be made pursuant to the terms of the applicable policy.

Date	Signature of Insured

Authorization of Waiving Coverage

This is to certify that I have been given an opportunity to elect group coverage available to me and my family members through my employer and I have decided to waive my right to coverage at this time. I understand I may later enroll for medical coverage or any other coverage if my family status changes or at open enrollment. I have read and understand the requirements. I understand that it is my responsibility to report to my employer any change in my family (or individual) status. I will provide proof of other coverage by attaching a copy of my insurance card to be eligible for cash in lieu of (if applicable).

I understand that if, in the future, I wish to participate in the coverages herein declined, and I am not eligible for a special enrollment period, I and my eligible dependents will have to satisfy any late enrollment conditions that the plan may require before coverage can become effective or wait until the Plan's next Open Enrollment.

PROOF OF OTHER COVERAGE IS REQUIRED

PRINT NAME: ______________________________

EMPLOYEE SIGNATURE: ______________________________ **DATE:** ______________