MEDICAL, DENTAL AND VISION INSURANCE ENROLLMENT/CHANGE FORM

For BVSD Use:
HR Rep ____________
Date ____________

Read all Plan Summaries before completing this form. This form is for BVSD benefit eligible employees enrolling or dropping medical, dental or vision coverage. Please return it to BVSD Human Resources. Rates listed are monthly.

Section 1: What you want to do

RATES IN EFFECT FOR PLAN YEAR JULY 1, 2015 - JUNE 30, 2016

☐ **NEW ENROLLMENT** ☐ **CHANGE** ☐ **CANCEL ALL COVERAGE**

EFFECTIVE DATE OF COVERAGE / CHANGE *(MM/DD/CCYY)* _____/_____/_________

COVERAGE OPTIONS with monthly rates:	Medical Plan: Cigna Standard	Medical Plan: Cigna Basic	Medical Plan: Kaiser	Dental Plan: Delta Dental	Vison Plan: VSP
1 Myself	1 ☐ $0	☐ $0	☐ $0	1 ☐ $0	1 ☐ $8.38
2 Myself & my spouse OR one child	2 ☐ $582	☐ $183	☐ $370	2 ☐ $30	2 ☐ $16.78
3 Myself & my children	3 ☐ $741	☐ $290	☐ $497	3 ☐ $35	3 ☐ $17.96
4 Myself & my family	4 ☐ $1274	☐ $641	☐ $924	4 ☐ $62	4 ☐ $28.70

CHANGE INFORMATION:

☐ Adding a dependent/spouse
☐ Dropping a dependent/spouse
☐ Transfering to a different plan

Reason for change:

Section 2: About You

Employee Name (Last / First / MI)	Employee ID #	Sex	Social Security #	Position/School or Department

Employee Date of Birth *(MM/DD/CCYY)*	Home Phone	Work Phone	Date of Hire

Home Address (Street)	City	State	Zip Code

Section 3: List Dependents (Attach additional sheet for more dependent children)

Last Name	First Name	M.I.	Sex	Date of Birth	Social Security #	Coverage Selection	Check one
Spouse /Domestic Partner						☐ Medical ☐ Dental ☐ Vision	☐ Add ☐ Drop
Child						☐ Medical ☐ Dental ☐ Vision	☐ Add ☐ Drop
Child						☐ Medical ☐ Dental ☐ Vision	☐ Add ☐ Drop
Child						☐ Medical ☐ Dental ☐ Vision	☐ Add ☐ Drop

Section 4: Conditions for Enrollment

The information provided above is true and correct to the best of my knowledge. I authorize any health care provider, insurance company, or other organization, institution, or person that has any information regarding my benefit eligibility or claims to release such information to the claims administrator. A copy of this authorization shall be considered as effective and valid as the original. I understand that any misrepresentation on this document may result in my coverage being void as of its effective date with no benefits payable. Employees covering dependents and/or enrolled in the Vison Plan have premiums deducted from each monthly paycheck. This is part of the district's Section 125 plan. Pre-tax deductions increase your take home pay but reduce your PERA eligible salary. Post-tax deductions reduce your take home pay but maximize your PERA eligible salary. If you are within 4 years of retirement, take time to evaluate whether or not you should participate in a Section 125 plan. Most employees who are considering retirement in four years or less choose post-tax. Almost everyone else chooses pre-tax. It only matters if you are covering dependents and/or enrolled in the vision plan.

Select one and Sign:

I authorize BVSD to make pre-tax payroll deductions to pay for the medical coverage I have elected. ☐ PRE-TAX ______________________________

Employee Signature Date

OR

I authorize BVSD to make post-tax payroll deductions to pay for the medical coverage I have elected. ☐ POST-TAX ______________________________

Employee Signature Date

Rev 3/25/13