BILLINGS PUBLIC SCHOOLS
2020/2021 MEDICAL/DENTAL/VISION ENROLLMENT FORM

Rates Effective July 1, 2020

*********Any employee with a change in eligible covered dependents must also complete a new BPS Benefits Enrollment Form.**********

MONTHLY RATES: **Please Circle your choices below.**

Plan C Medical Insurance Premiums	Employee $703	Employee +1 $1,119	Employee +Children $1,159	Family $1,350
Dental Insurance Premiums (member must be on the medical plan to enroll in dental)	Employee $57	Employee + 1 $97	Employee + Children $110	Family $128
Vision Insurance Premiums	Employee $10.38	Emp+Spouse $20.79	Emp. w/Child(ren) $22.20	Family $35.48

NAME:_____**SOC. SEC. #:**_____

DIST. I.D.#:_____**PHONE:**_____**FTE:**_____

Please Circle Your Unit: **BEA** **BCEA** **MPEA** **ADMIN** **CONTRACT**

PLEASE SELECT ONE PLAN : MED_____DEN _____ + VIS _____= Total: $_____(A)

DISTRICT CONTRIBUTION (The contribution is $760 for full time teachers/administrators and staff working over 20 hours a week) $_____(B)

SUBTRACT LINE B FROM LINE A. LINE C = EMPLOYEE COST EACH MONTH: $_____(C)

Your premium cost (line C) will be deducted pre-tax. There is NO FEE for the pre-tax premium deduction.
If you want your premium deducted after-tax, you must contact the Insurance Office and sign a "Premium Pre-Tax Declination Form".

With regard to my salary reduction agreement and my election of benefits, I understand that: *I may not change elections during the Plan Year unless there is a change in my family status. *The Administrator is authorized to adjust the amount of my salary reductions and benefits if it is necessary to satisfy certain provisions of the Internal Revenue Code or as a result of changes in premiums for benefits that are insured. ***My election of salary reductions for medical/dental/vision benefits will remain in effect only for the Plan Year for which these elections are made. Failure to sign a new election form during the election period prior to each subsequent Plan Year will be considered an election to participate in the Plan for the Plan Year at the level of benefits selected for the previous year.**

X_____ _____

Authorization Signature **Date**

DECLINATION OF PARTICIPATION:
I have been given the opportunity to participate in the **Medical/Dental/Vision Plan** and have elected not to do so.

BCEA, MPEA OR Part-time BEA ONLY

_____ _____

Signature for Declination of Coverage Date