BILLINGS PUBLIC SCHOOLS
BENEFITS ENROLLMENT FORM

Please fill out this form in its entirety.

Name _____ Social Security # _____
Last First MI

Mailing Address _____ School District I.D. # _____

_____ Phone #_____
City State Zip Code

Home School _____ Occupation _____

Birth Date _____/_____/_____
Month Day Year

Male ☐ Female ☐

Single ☐ Widowed ☐

Married ☐ Divorced ☐

IS YOUR SPOUSE EMPLOYED? Yes ☐ No ☐
If so, where?

DO YOU HAVE OTHER INSURANCE? Yes ☐ No ☐
If you or any of your eligible dependents are eligible for other health benefits coverage, please provide the name of the company.

TYPE OF MEDICAL PLAN Employee ☐ Employee + One ☐ Employee + Children ☐ Family ☐

DEPENDENTS COVERED ON MEDICAL PLAN	SOCIAL SECURITY #	SEX	DATE OF BIRTH	RELATIONSHIP
Spouse:	(- -)			
Children:	(- -)			
	(- -)			
	(- -)			
	(- -)			
	(- -)			
	(- -)			
	(- -)			
	(- -)			

Beneficiary for $50,000 Life Insurance Policy **Relationship**

Primary(ies) _____ _____

Contingent(s) _____ _____

X_____ _____
Signature of Applicant **Date**

FOR OFFICE USE

Emp Date_____ **Ins Eff Date** _____ **Div** _____ **FTE**_____

Notes: