BCSD
Berea City School District
EXCELLENCE • INTEGRITY • PURPOSE
Serving Berea, Brook Park and Middleburg Heights

Berea City School District

Enrollment Application/Change Form

REASON FOR APPLICATION	QUALIFYING EVENT/Change
New Hire Rehire Date Hired/Rehired: / / Annual Open Enrollment Qualifying Event/Change ***Checking this Box requires additional enrollment form to be completed***	Event Date / / Change in Marital Status/Name Birth/Adoption Legal Guardianship Loss of Coverage Change of Hours Change to Medicare Eligible ***Legal Documentation Evidencing the Event/Change is Required***

TYPE OF COVERAGE/PLAN

MEDICAL MUTUAL Medical/Prescription	FLEX (FSA) Flexible Spending Account	MetLife Dental Coverage	MetLife Vision Coverage
Healthy Living Plan Single Coverage Family Coverage **Economy Plan** Single Coverage Family Coverage **NO COVERAGE**	**An additional enrollment Form is required for FSA.** Medical Dependent Care **DECLINE**	**Premium Dental Plan** Employee Only Family Coverage Spouse Child(ren) **Economy Dental Plan** Employee Only Family Coverage Spouse Child(ren) ☐ **NO COVERAGE**	Employee Only Family Coverage Spouse Child(ren) **NO COVERAGE**

EMPLOYEE INFORMATION

Last Name First Name Initial Date of Birth / / Age Female Male Gender

/ / Social Security No. **(Required)** Single Married Widowed Legally Separated Divorced

Home Address City State Zip County

- - Home Phone - - Work Phone @bereaschools.org Email Address

MEDICARE INFORMATION

Are **You** covered by Medicare? NO YES- Medicare No. Effective Date: / /

Is **Your Spouse** covered by Medicare? NO YES- Medicare No. Effective Date: / /

_____ Date: _____
Signature

FAMILY INFORMATION

(If Family coverage – this information is required.)

DEPENDENT 1 Relationship to Applicant: ☐ Spouse ☐ Child ☐ Stepchild ☐ Other

Dependent's Last Name | First Name | Initial | Date of Birth / / | Age | ☐ Male ☐ Female Gender

Social Security No. **(Required)** / / Eligible for Federal income tax exemption? ☐ Yes ☐ No

Court ordered health care coverage? ☐ Yes ☐ No (**If YES** – attach legal documentation – required)

☐ Resides at the same address as employee – **OR -** ☐ does not reside at the same address - **provide address below**.

Home Address | City | State | Zip | County

DEPENDENT 2 Relationship to Applicant: ☐ Spouse ☐ Child ☐ Stepchild ☐ Other

Dependent's Last Name | First Name | Initial | Date of Birth / / | Age | ☐ Male ☐ Female Gender

Social Security No. **(Required)** / / Eligible for Federal income tax exemption? ☐ Yes ☐ No

Court ordered health care coverage? ☐ Yes ☐ No (**If YES** – attach legal documentation – required)

☐ Resides at the same address as employee – **OR -** ☐ does not reside at the same address - **provide address below**.

Home Address | City | State | Zip | County

DEPENDENT 3 Relationship to Applicant: ☐ Spouse ☐ Child ☐ Stepchild ☐ Other

Dependent's Last Name | First Name | Initial | Date of Birth / / | Age | ☐ Male ☐ Female Gender

Social Security No. **(Required)** / / Eligible for Federal income tax exemption? ☐ Yes ☐ No

Court ordered health care coverage? ☐ Yes ☐ No (**If YES** – attach legal documentation – required)

☐ Resides at the same address as employee – **OR -** ☐ does not reside at the same address - **provide address below**.

Home Address | City | State | Zip | County

DEPENDENT 4 Relationship to Applicant: ☐ Spouse ☐ Child ☐ Stepchild ☐ Other

Dependent's Last Name | First Name | Initial | Date of Birth / / | Age | ☐ Male ☐ Female Gender

Social Security No. **(Required)** / / Eligible for Federal income tax exemption? ☐ Yes ☐ No

Court ordered health care coverage? ☐ Yes ☐ No (**If YES** – attach legal documentation – required)

☐ Resides at the same address as employee – **OR -** ☐ does not reside at the same address - **provide address below**.

Home Address | City | State | Zip | County