

Welcome to the Bakersfield City School District

Please read the information and complete ONLY the highlighted portions of the attached enrollment forms.

By completing the attached SISC III ENROLLMENT FORM, you and any eligible dependents will automatically be enrolled in our Medical and Vision plan.

When enrolling a spouse you must provide a copy of your marriage certificate and a copy of the first page of your current Federal Tax Return. When enrolling dependent children you must provide a copy of their birth certificate. Social Security Numbers must be provided for all members. **Your request will not be processed until all requested information is received.**

You must specify on this form which dental plan you like to enroll in:

- ☐ Delta Dental Incentive \$1,500 max a year, 70% first year, 80% second, 90% third, 100% fourth year
- ☐ Delta Dental PPO \$2,000 max a year. 100% coverage, NO COPAY if in network.
- ☐ Liberty Dental-*complete and return attached Liberty enrollment form*
HMO, Covers Ortho with \$1,000 copay, No Max.

You must also complete all pages of the Guardian Life Insurance forms.

Name: _____ Date: _____

Social Security No: _____

SISC III ENROLLMENT FORM – (DO NOT use for Kaiser members, use Kaiser Permanente enrollment form for Kaiser members)

(Type or print clearly in black ink)

SECTION I: SELECTED COVERAGE – REQUIRED (DISTRICT USE ONLY)ENROLLMENT REASON: ☐ NEW HIRE ☐ OPEN ENROLLMENT ☐ EMPLOYEE STATUS CHANGE ☐ LOSS OF COVERAGE ☐ COBRA

QUALIFYING DATE: _____ EFFECTIVE DATE: _____ HIRE DATE: _____ DISTRICT APPROVED INITIALS: _____

DISTRICT NAME (DO NOT ABBREVIATE)

Bakersfield City School District

EMPLOYEE GROUP (BARGAINING UNIT)

☐ Certified ☐ Classified ☐ Management

EMPLOYEE TYPE

☐ Full Time ☐ Part Time ☐ Vari/Temp/Seasonal

MEDICAL GROUP NO.

40028

DELTA DENTAL GROUP NO.

7073-

VISION GROUP NO.

1038291-1001/ABN

LIFE GROUP NO.

N/A

SECTION II: EMPLOYEE / APPLICANT INFORMATION - REQUIRED

☐ MEDICAL ☐ DENTAL ☐ VISION ☐ LIFE	SOCIAL SECURITY NO.	LAST NAME (PRINT)	FIRST NAME (PRINT)	MI	DATE OF BIRTH ____/____/____	☐ MALE ☐ FEMALE
STREET ADDRESS			CITY	STATE CA	ZIP	
TELEPHONE NO. ()		E-MAIL ADDRESS	IPA (HMO ONLY-REQUIRED)	PCP (HMO ONLY-REQUIRED)	CURRENT PROVIDER? ☐ YES ☐ NO	

MEDICARE COVERAGE If you are retired and entitled to Medicare and not enrolled, you may be subject to a premium surcharge.Are you retired? ☐ YES ☐ NOIf yes, do you have Medicare? ☐ YES ☐ NO

(Copy of Medicare card required)

TOTALLY DISABLED? ☐ YES ☐ NODo any of your dependents have Medicare? ☐ YES ☐ NO

(Copy of Medicare card required)

SECTION III: DEPENDENT INFORMATION Proof of eligibility required (i.e. birth/marriage/domestic partner certificate)

☐ MEDICAL ☐ DENTAL ☐ VISION	☐ Spouse ☐ Domestic Partner Gender ☐ M ☐ F	LAST NAME (PRINT)	FIRST NAME (PRINT)	MI	SOCIAL SECURITY NO.	ELIGIBLE FOR OTHER HEALTH PLAN? ☐ YES ☐ NO	ENROLLED IN OTHER HEALTH PLAN? ☐ YES ☒ NO	DATE OF BIRTH ____/____/____	TOTALLY DISABLED? ☐ YES ☐ NO	IPA (HMO ONLY-REQUIRED)	PCP (HMO ONLY-REQUIRED)	IS THIS YOUR CURRENT PROVIDER? ☐ YES ☐ NO
☐ MEDICAL ☐ DENTAL ☐ VISION	☐ SON ☐ DAUGHTER	LAST NAME (PRINT)	FIRST NAME (PRINT)	MI	SOCIAL SECURITY NO.	ELIGIBLE FOR OTHER HEALTH PLAN? ☐ YES ☐ NO	ENROLLED IN OTHER HEALTH PLAN? ☐ YES ☐ NO	DATE OF BIRTH ____/____/____	TOTALLY DISABLED? ☐ YES ☐ NO	IPA (HMO ONLY-REQUIRED)	PCP (HMO ONLY-REQUIRED)	IS THIS YOUR CURRENT PROVIDER? ☐ YES ☐ NO
☐ MEDICAL ☐ DENTAL ☐ VISION	☐ SON ☐ DAUGHTER	LAST NAME (PRINT)	FIRST NAME (PRINT)	MI	SOCIAL SECURITY NO.	ELIGIBLE FOR OTHER HEALTH PLAN? ☐ YES ☐ NO	ENROLLED IN OTHER HEALTH PLAN? ☐ YES ☐ NO	DATE OF BIRTH ____/____/____	TOTALLY DISABLED? ☐ YES ☐ NO	IPA (HMO ONLY-REQUIRED)	PCP (HMO ONLY-REQUIRED)	IS THIS YOUR CURRENT PROVIDER? ☐ YES ☐ NO
☐ MEDICAL ☐ DENTAL ☐ VISION	☐ SON ☐ DAUGHTER	LAST NAME (PRINT)	FIRST NAME (PRINT)	MI	SOCIAL SECURITY NO.	ELIGIBLE FOR OTHER HEALTH PLAN? ☐ YES ☒ NO	ENROLLED IN OTHER HEALTH PLAN? ☐ YES ☐ NO	DATE OF BIRTH ____/____/____	TOTALLY DISABLED? ☐ YES ☐ NO	IPA (HMO ONLY-REQUIRED)	PCP (HMO ONLY-REQUIRED)	IS THIS YOUR CURRENT PROVIDER? ☐ YES ☐ NO

- I understand it is my responsibility to notify my district once a dependent is no longer eligible due to divorce or over age children. If I fail to report loss of eligibility I may be financially liable to SISC if claims were paid on behalf of non-eligible individuals.
- DEDUCTION AUTHORIZATION: If applicable, I authorize my school district to deduct from my wages the required contribution.
- NON-PARTICIPATING PROVIDER: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.
- HIV Testing Prohibited: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.
- EFFECTIVE DATE: The effective date of coverage is subject to SISC III approval.
- Any complaints regarding the exemption due to the Knox-Keene Health Care Service Plan Act of 1975 may be directed to the Department of Managed Health Care of the State of California.

ECTION IV: SIGNATURE OF UNDERSTANDING – APPLICANT MUST SIGN

I have read and understand the provisions outlined on this form. All information on this form is correct and true. I understand that it is the basis on which coverage may be issued under the plan. Any misstatements or omissions may result in future claims being denied and/or the policy being rescinded. You are entitled to a copy of this signed authorization for your files. Additionally, any person who knowingly and with intent to injure, defraud, or deceive the district, SISC, or plan service provider, by filing a statement or claim containing false or misleading information may be guilty of a criminal act punishable under law. I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements.

ARBITRATION AGREEMENT: I UNDERSTAND THAT ANY AND ALL DISPUTES BETWEEN MYSELF (AND/OR ANY ENROLLED FAMILY MEMBER) AND SISC III (INCLUDING CLAIMS ADMINISTRATOR OR AFFILIATE) INCLUDING CLAIMS FOR MEDICAL MALPRACTICE, MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF THE SMALL CLAIMS COURT, AND NOT BY LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. UNDER THIS COVERAGE, BOTH THE MEMBER AND SISC III ARE GIVING UP THE RIGHT TO HAVE ANY DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY. SISC III AND THE MEMBER ALSO AGREE TO GIVE UP ANY RIGHT TO PURSUE ON A CLASS BASIS ANY CLAIM OR CONTROVERSY AGAINST THE OTHER. (FOR MORE INFORMATION REGARDING BINDING ARBITRATION, PLEASE REFER TO YOUR EVIDENCE OF COVERAGE BOOKLET.)

Applicant Signature Required

Date



LIBERTY Dental Plan
888-703-6999
www.libertydentalplan.com
APPLICATION FOR MEMBERSHIP

Employer's Use Only	
Group # 101306	Effective Date: _____
☐ COBRA Enrollment	COBRA End Date: _____

Last Name		First Name		MI	Social Security Number		Birth Date	
Street Address		City		State	Zip Code	Telephone ()		Sex

LIST ALL DEPENDENTS TO BE COVERED UNDER YOUR PLAN

Last Name	First Name	Sex	Birth Date
Spousal Domestic Partner			
Child			
Child			
Child			
Child			
Child			
Child			

Bakersfield City School District

Name of Employer/Trust

Provider ID Number

Language Preference

☐ New Enrollment

☐ Add Dependent

☐ Address Change

☐ Delete Dependent

Employee E-mail Address

Employee Signature

Date

White: LIBERTY Dentist Plan Copy

Yellow: HR Copy

Pink: Employee Copy



Your life coverage

	BASIC LIFE	VOLUNTARY TERM LIFE
Employee Benefit	Your employer provides \$50,000 Basic Term Life coverage for all full time employees.	\$50,000 increments to a maximum of \$150,000. See Cost Illustration page for details.
Accidental Death and Dismemberment	Your Basic Life coverage includes Enhanced Accidental Death and Dismemberment coverage.	Not available
Spouse/Domestic Partner Benefit	Your spouse/domestic partner is eligible for coverage in the amount of \$5,500.	\$5,000 increments to a maximum of \$50,000. See Cost Illustration page for details.
Child Benefit	Your dependent children ages birth† to 26, are eligible for coverage in the amount of \$5,500. See enrollment form for details.	Your dependent children age birth† to 26 years. You may elect one of the following benefit options: \$10,000. Subject to state limits. See Cost Illustration page for details.
Guarantee Issue: The 'guarantee' means you are not required to answer health questions to qualify for coverage up to and including the specified amount, when you sign up for coverage during the initial enrollment period.	Guarantee Issue coverage up to \$50,000 per employee	We Guarantee Issue coverage up to: Employee \$150,000. Spouse \$50,000. Dependent children \$10,000.
Premiums	Covered by your company if you meet eligibility requirements	Increase on plan anniversary after you enter next five-year age group
Portability: Allows you to take coverage with you if you terminate employment.	Yes, with age and other restrictions	Yes, with age and other restrictions
Conversion: Allows you to continue your coverage after your group plan has terminated.	Yes, with restrictions; see certificate of benefits	Yes, with restrictions; see certificate of benefits
Accelerated Life Benefit: A lump sum benefit is paid to you if you are diagnosed with a terminal condition, as defined by the plan.	Yes	Yes

Your life coverage

	BASIC LIFE	VOLUNTARY TERM LIFE
Waiver of Premiums: Premium will not need to be paid if you are totally disabled.	For employees disabled prior to age 60, with premiums waived until age 70, if conditions are met	For employees disabled prior to age 60, with premiums waived until age 70, if conditions met
Benefit Reductions: Benefits are reduced by a certain percentage as an employee ages.	30% at age 65, 50% at age 70, 70% at age 75	30% at age 65, 50% at age 70, 70% at age 75

Subject to coverage limits

† Basic Life and Voluntary Life: Infant coverage is limited based on age.

The Guarantee Issue amount may be subject to reductions by percentage at the ages shown in this summary.

Automatic Increase allows for 5 adjustments of 5% each to the Voluntary Life benefit amount for members whose coverage has been inforce for at least one year. The adjustments are calculated at the time of claim.

LIMITATIONS AND EXCLUSIONS:

A SUMMARY OF PLAN LIMITATIONS AND EXCLUSIONS FOR LIFE AND AD&D COVERAGE:

You must be working full-time on the effective date of your coverage; otherwise, your coverage becomes effective after you have completed a specific waiting period. Employees must be legally working in the United States in order to be eligible for coverage. Underwriting must approve coverage for employees on temporary assignment: (a) exceeding one year; or (b) in an area under travel warning by the US Department of State. Subject to state specific variations. Evidence of Insurability is required on all late enrollees. This coverage will not be effective until approved by a Guardian underwriter. This proposal is hedged subject to satisfactory financial evaluation. Please refer to certificate of coverage for full plan description.

Dependent life insurance will not take effect if a dependent, other than a newborn, is confined to the hospital or other health care facility or is unable to perform the normal activities of someone of like age and sex.

Accelerated Life Benefit is not paid to an employee under the following circumstances: one who is required by law to use the benefit to pay creditors; is required by court order to pay the benefit to another person; is required by a government agency to use the payment to receive a government benefit; or loses his or her group coverage before an accelerated benefit is paid.

Voluntary Life Only:

We pay no benefits if the insured's death is due to suicide within two years from the insured's original effective date. This two year limitation also applies to any increase in benefit. This exclusion may vary according to state law. Late entrants and benefit increases require underwriting approval.

GP-I-R-LB-90, GP-I-R-EOPT-96

Guarantee Issue/Conditional Issue amounts may vary based on age and case size. See your Plan Administrator for details. Late entrants and benefit increases require underwriting approval.

For AD&D: We pay no benefits for any loss caused: by willful self-injury; sickness, disease or medical treatment; by participating in a civil disorder or committing a felony; Traveling on any type of aircraft while having duties on that aircraft; by declared or undeclared act of war or armed aggression; while a member of any armed force (May vary by state); while driving a motor vehicle without a current, valid driver's license; by legal intoxication; or by voluntarily using a non-prescription controlled substance. Contract #GP-I-R-ADCL1-00 et al. We won't pay more than 100% of the Insurance amount for all losses due to the same accident, except as stated. The loss must occur within a specified period of time of the accident. Please see contract for specific definition; definition of loss may vary depending on the benefit payable.

Enhanced AD&D: A loss may be defined as death, quadriplegia, loss of speech and hearing, loss of cognitive function, comatose state in excess of one month, hemiplegia or paraplegia. The loss must occur within a specified period of time of the accident. Please see contract for specific definition; definition of loss may vary depending on the benefit payable.

Guardian Group Life Insurance underwritten and issued by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage.
Policy Form # GP-1-LIFE-15

Guardian Life, P.O. Box 14319,
Lexington, KY 40512

Please print clearly and mark carefully.

Employer/Planholder Name: BAKERSFIELD CITY SCHOOL DISTRICT	Group Plan Number: 00501890	Benefits Effective: _____
PLEASE CHECK APPROPRIATE BOX ☐ Initial Enrollment ☐ Add Employee/Member Dependents/Family Members ☐ Drop/Refuse Coverage ☐ Information Change		
<p>In this form, you will be referred to as an Employee/Member. Members of your family will be referred to as Dependents/Family Members. There will also be times, when referring to Dependents/Family Members, this form will distinguish between your spouse and your children. Depending on the type of plan your Planholder selected, other plan documents may refer to you as an employee, a member, or a similar term, and, to members of your family, as family members, dependents, eligible dependents, or a similar term. Please refer to the group policy, certificate of coverage, (sometimes called a member guide), to see how terms are defined and to determine which members of your family are eligible for coverage. Plan documents such as the group policy, certificate of coverage, (sometimes called a member guide), control if there is any dispute concerning the meaning of terms used in this form.</p>		

Class: _____	Division: _____	Subtotal Code: _____	(Please obtain this from your Employer/Planholder)
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About You: Full Legal Name-First, MI, Last Name: _____ What is the name you go by? (optional) _____	Employer/Planholder Provided Identification: _____	Social Security Number _____ - _____ - _____ Your Social Security Number must be provided if enrolling for Life Coverage. Short Term Disability Coverage and/or Long Term Disability Coverage.	
Address _____	City _____	State _____	Zip _____
Gender Identity: ☐ M ☐ F Date of Birth (mm-dd-yy): ____ - ____ - ____			
Phone (indicate primary): ☐ Home (____) ____ - ____ ☐ Work (____) ____ - ____ ☐ Mobile (____) ____ - ____			
E mail Address (indicate primary) ☐ Home _____ ☐ Work _____			
Are you married or in a domestic partnership? ☐ Yes ☐ No Date of marriage/domestic partnership: ____ - ____ - ____ Do you have children or other dependents? ☐ Yes ☐ No Placement date of adopted child: ____ - ____ - ____			

About Your Job:	Job Title: _____
Work Status: ☐ Active ☐ Retired ☐ COBRA/State Continuation Hours worked per week: _____	Date of full time hire: ____ - ____ - ____ Annual Salary: \$ _____

About Your Family: Please include the names of the Dependents/Family Members you wish to enroll. You can enroll only those Dependents/Family Members that are eligible for coverage. Please refer to the plan documents such as the group policy, member guide, or certificate to determine if a Dependent/Family Member is eligible for coverage.			
If additional space is needed, please attach a separate page with this information along with your enrollment form. Each Dependent/Family Member's Social Security Number must be provided if enrolling them for Life Coverage. Be sure to sign and date (mm-dd-yyyy) the paper and keep a copy for your records. Additional information may be required for non-standard dependents such as a niece or a nephew.			
Spouse Address/City/State/Zip: _____ Phone: () - ____ - ____	Gender Identity: ☐ M ☐ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	

Child/Dependent 1: Address/City/State/Zip: Phone: () -	☐ Add ☐ Drop	Gender Identity: ☐ M ☐ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) _____ - _____ - _____	Status (check as applicable) ☐ Student (post high school) ☐ Disabled ☐ Non standard dependent
Child/Dependent 2: Address/City/State/Zip: Phone: () -	☐ Add ☐ Drop	Gender Identity: ☐ M ☐ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) _____ - _____ - _____	Status (check as applicable) ☐ Student (post high school) ☐ Disabled ☐ Non standard dependent
Child/Dependent 3: Address/City/State/Zip: Phone: () -	☐ Add ☐ Drop	Gender Identity: ☐ M ☐ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) _____ - _____ - _____	Status (check as applicable) ☐ Student (post high school) ☐ Disabled ☐ Non standard dependent
Child/Dependent 4: Address/City/State/Zip: Phone: () -	☐ Add ☐ Drop	Gender Identity: ☐ M ☐ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) _____ - _____ - _____	Status (check as applicable) ☐ Student (post high school) ☐ Disabled ☐ Non standard dependent

Drop Coverage: ☐ Drop Employee/Member ☐ Drop Dependents/Family Members The date of withdrawal cannot be prior to the date this form is completed and signed. Last Day of Coverage: _____ - _____ - _____ ☐ Termination of Employment ☐ Retirement Last Day Worked: _____ - _____ - _____ ☐ Other Event: _____ Date of Event: _____ - _____ - _____	Coverage Being Dropped: ☐ Basic Term Life ☐ Employee/Member ☐ Spouse ☐ Child(ren) ☐ Voluntary Term Life ☐ Employee/Member ☐ Spouse ☐ Child(ren)
I have been offered the above coverage(s) and wish to drop enrollment for the following reasons: ☐ Covered under another insurance plan ☐ Other _____ (additional information may be required)	

Basic Life Coverage with Accidental Death and Dismemberment (AD&D): You must be enrolled to cover your dependents/family members.

Benefit reductions apply. Please see plan administrator.

The amount of life insurance coverage you select may be either a specific dollar amount or an amount that is a multiple of your salary and may be subject to certain reductions.

Policy Amount
Employee/Member Only
☒ \$50,000

The Guarantee Issue Amount is \$50,000.

* If Employee/Member is 65+ benefit reductions may apply which may change the GI amount. Please see enrollment materials for details.

Spouse or Partner
☒ \$5,500

**The amount may not be more than 50% of the Employee/Member amount*

Child/Dependent
☒ \$5,500

**The amount may not be more than 10% of the Employee/Member amount*

Employee/Member Name your beneficiaries: (Primary beneficiary percentages must total 100%)

If additional space is needed, please attach a separate sheet of paper with this information along with your enrollment form. Be sure to sign and date (mm-dd-yy) the paper and keep a copy for your records.

Primary Beneficiaries:

Name: _____ Social Security Number: _____ - _____ %

Date of Birth (mm-dd-yy): _____ - _____ - _____

Address/City/State/Zip: _____

Phone: () - _____ Relationship to Employee/Member: _____

Name: _____ Social Security Number: _____ - _____ %

Date of Birth (mm-dd-yy): _____ - _____ - _____

Address/City/State/Zip: _____

Phone: () - _____ Relationship to Employee/Member: _____

Contingent Beneficiary: _____ Social Security Number: _____ - _____ - _____

Date of Birth (mm-dd-yy): _____ - _____ - _____

Address/City/State/Zip: _____

Phone: () - _____ Relationship to Employee/Member: _____

(In the event the primary beneficiaries are deceased, the contingent beneficiary will receive the benefit. Employer/Planholder maintains beneficiary information.)

Dependents/Family Members – If the intended beneficiary is to be someone other than the Employee/Member, please complete the Beneficiary Designation form.

Attention: If any of the beneficiaries named above is a minor (a person under the age of 18 or 21, depending on their state of residency), state law may limit Guardian's ability to pay life insurance proceeds directly to them for as long as they remain a minor. State Uniform Transfers to Minors Act (UTMA) laws, where applicable, may allow for the normal course of payment of these proceeds, or a portion thereof, to the minor beneficiary's designated Custodian to manage on the minor's behalf until they reach adult age. At that time, the proceeds are turned over to the adult child, who can use the proceeds in any way he or she chooses.

Are any of the beneficiaries identified above considered a minor in the state in which they reside? Check one box only. ☐ Yes ☐ No

If you answered "Yes", please name the legally designated UTMA Custodian for all minor beneficiaries you have designated:

Custodian to Minor Beneficiaries:

Name: _____ Social Security Number (or FEIN/TIN # if a corporate entity): _____ - _____

Date of Birth (mm-dd-yyyy) (if an individual): _____ - _____ - _____

Address/City/State/Zip: _____

Phone: () - _____

If this Basic Life coverage will replace your existing life insurance coverage through your current Employer/Planholder, provide the amount of the previous policy \$ _____

Important Notes:

- Based on your plan benefits and age, you may be required to complete an evidence of insurability form.

LIFE INSURANCE *continued*

Voluntary Term Life Coverage: You must be enrolled to cover your dependents/family members. *Benefit reductions apply. Please see plan administrator.*

The amount of life insurance coverage you select may be either a specific dollar amount or an amount that is a multiple of your salary and may be subject to certain reductions.

Employee/Member

Policy Amount

Check one box only

☐ \$50,000

☐ \$100,000

☐ \$150,000*

*Guarantee Issue Amount. The Health History section must be completed if any amount above the Guarantee Issue Amount is elected.

☐ I do not want this coverage

Add Voluntary Life for Spouse or Partner

Policy Amount

☐ \$5,000

☐ \$10,000

☐ \$15,000

☐ \$20,000

☐ \$25,000

☐ \$30,000

☐ \$35,000

☐ \$40,000

☐ \$45,000

☐ \$50,000*

*Guarantee Issue Amount

*The amount may not be more than 50% of the employee amount for Voluntary Life.

☐ I do not want this coverage

Add Voluntary Life for Dependent/Child(ren)

Policy Amount

☐ \$10,000*

*Guarantee Issue Amount

*The amount may not be more than 50% of the employee amount for Voluntary Life.

☐ I do not want this coverage

Important Notes:

- Based on your plan benefits and age, you may be required to complete an evidence of insurability form.

Voluntary Life Cost Illustration:

To determine the most appropriate level of coverage, as a rule of thumb, you should consider about 6 - 10 times your annual income, factoring in projected costs to help maintain your family's current life style.

12 Month premiums displayed. Policy Election Cost Per Age Bracket

Employee	Policy Amounts	< 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-99
	\$50,000.00	\$3.50	\$5.00	\$6.50	\$7.50	\$15.50	\$26.50	\$42.00	\$64.50	\$121.00	\$216.50
	\$100,000.00	\$7.00	\$10.00	\$13.00	\$15.00	\$31.00	\$53.00	\$84.00	\$129.00	\$242.00	\$433.00
	\$150,000.00	\$10.50	\$15.00	\$19.50	\$22.50	\$46.50	\$79.50	\$126.00	\$193.50	\$363.00	\$649.50

Spouse	Policy Amounts	< 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-99
	\$5,000.00	\$0.35	\$0.50	\$0.65	\$0.75	\$1.55	\$2.65	\$4.20	\$6.45	\$12.10	\$21.65
	\$10,000.00	\$0.70	\$1.00	\$1.30	\$1.50	\$3.10	\$5.30	\$8.40	\$12.90	\$24.20	\$43.30
	\$15,000.00	\$1.05	\$1.50	\$1.95	\$2.25	\$4.65	\$7.95	\$12.60	\$19.35	\$36.30	\$64.95
	\$20,000.00	\$1.40	\$2.00	\$2.60	\$3.00	\$6.20	\$10.60	\$16.80	\$25.80	\$48.40	\$86.60
	\$25,000.00	\$1.75	\$2.50	\$3.25	\$3.75	\$7.75	\$13.25	\$21.00	\$32.25	\$60.50	\$108.25
	\$30,000.00	\$2.10	\$3.00	\$3.90	\$4.50	\$9.30	\$15.90	\$25.20	\$38.70	\$72.60	\$129.90
	\$35,000.00	\$2.45	\$3.50	\$4.55	\$5.25	\$10.85	\$18.55	\$29.40	\$45.15	\$84.70	\$151.55
	\$40,000.00	\$2.80	\$4.00	\$5.20	\$6.00	\$12.40	\$21.20	\$33.60	\$51.60	\$96.80	\$173.20
	\$45,000.00	\$3.15	\$4.50	\$5.85	\$6.75	\$13.95	\$23.85	\$37.80	\$58.05	\$108.90	\$194.85
	\$50,000.00	\$3.50	\$5.00	\$6.50	\$7.50	\$15.50	\$26.50	\$42.00	\$64.50	\$121.00	\$216.50

Child(ren)	Policy Amounts	Premium
	\$10,000.00	\$1.60

10 Month Premium per pay period. Policy Election Cost Per Age Bracket

Employee	Policy Amounts	< 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-99
	\$50,000.00	\$4.20	\$6.00	\$7.80	\$9.00	\$18.60	\$31.80	\$50.40	\$77.40	\$145.20	\$259.80
	\$100,000.00	\$8.40	\$12.00	\$15.60	\$18.00	\$37.20	\$63.60	\$100.80	\$154.80	\$290.40	\$519.60
	\$150,000.00	\$12.60	\$18.00	\$23.40	\$27.00	\$55.80	\$95.40	\$151.20	\$232.20	\$435.60	\$779.40

Spouse	Policy Amounts	< 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-99
	\$5,000.00	\$0.42	\$0.60	\$0.78	\$0.90	\$1.86	\$3.18	\$5.04	\$7.74	\$14.52	\$25.98
	\$10,000.00	\$0.84	\$1.20	\$1.56	\$1.80	\$3.72	\$6.36	\$10.08	\$15.48	\$29.04	\$51.96
	\$15,000.00	\$1.26	\$1.80	\$2.34	\$2.70	\$5.58	\$9.54	\$15.12	\$23.22	\$43.56	\$77.94
	\$20,000.00	\$1.68	\$2.40	\$3.12	\$3.60	\$7.44	\$12.72	\$20.16	\$30.96	\$58.08	\$103.92
	\$25,000.00	\$2.10	\$3.00	\$3.90	\$4.50	\$9.30	\$15.90	\$25.20	\$38.70	\$72.60	\$129.90
	\$30,000.00	\$2.52	\$3.60	\$4.68	\$5.40	\$11.16	\$19.08	\$30.24	\$46.44	\$87.12	\$155.88
	\$35,000.00	\$2.94	\$4.20	\$5.46	\$6.30	\$13.02	\$22.26	\$35.28	\$54.18	\$101.64	\$181.86
	\$40,000.00	\$3.36	\$4.80	\$6.24	\$7.20	\$14.88	\$25.44	\$40.32	\$61.92	\$116.16	\$207.84
	\$45,000.00	\$3.78	\$5.40	\$7.02	\$8.10	\$16.74	\$28.62	\$45.36	\$69.66	\$130.68	\$233.82
	\$50,000.00	\$4.20	\$6.00	\$7.80	\$9.00	\$18.60	\$31.80	\$50.40	\$77.40	\$145.20	\$259.80

Child(ren)	Policy Amounts	Premium
	\$10,000.00	\$1.92

Refer to Guarantee Issue row on page above for Voluntary Life GI amounts. Premiums for Voluntary Life Increase in five-year increments

Infant coverage is limited for the first two weeks of infant's life. Spouse/DP coverage premium is based on Employee age. Benefit reductions apply.

The Guarantee Issue amount may be subject to reductions by percentage at the ages shown in this summary.

GUARDIAN is a registered trademark of The Guardian Life Insurance Company of America

BAKERSFIELD CITY SCHOOL DISTRICT
ALL ACTIVE EMPLOYEES

Kit created 07/11/2025 Group number: 00501890

LIFE INSURANCE *continued*

Employee/Member Only Name your beneficiaries: (Primary beneficiary percentages must total 100%) If electing different beneficiaries that are not the same as those named for Basic Life or Voluntary Term Life, please name below.

If additional space is needed, please attach a separate sheet of paper with this information along with your enrollment form. Be sure to sign and date (mm-dd-yyyy) the paper and keep a copy for your records.

Primary Beneficiaries:

Name: _____ Social Security Number: _____ - _____ - _____ % _____

Date of Birth (mm-dd-yy): _____ - _____ - _____ Address/City/State/Zip: _____

Phone: () - _____ Relationship to Employee/Member: _____

Name: _____ Social Security Number: _____ - _____ - _____ % _____

Date of Birth (mm-dd-yy): _____ - _____ - _____ Address/City/State/Zip: _____

Phone: () - _____ Relationship to Employee/Member: _____

Contingent Beneficiary: _____ Social Security Number: _____ - _____ - _____

Date of Birth (mm-dd-yy): _____ - _____ - _____ Address/City/State/Zip: _____

Phone: () - _____ Relationship to Employee/Member: _____

(In the event the primary beneficiaries are deceased, the contingent beneficiary will receive the benefit. Employer/Planholder maintains beneficiary information.)

Spouse or Partner and dependent/child(ren) – If the intended beneficiary is to be someone other than the Employee/Member, please complete the Beneficiary Designation form.

Attention: If any of the beneficiaries named above is a minor (a person under the age of 18 or 21, depending on their state of residency), state law may limit Guardian's ability to pay life insurance proceeds directly to them for as long as they remain a minor. State Uniform Transfers to Minors Act (UTMA) laws, where applicable, may allow for the normal course of payment of these proceeds, or a portion thereof, to the minor beneficiary's designated Custodian to manage on the minor's behalf until they reach adult age. At that time, the proceeds are turned over to the adult child, who can use the proceeds in any way he or she chooses.

Are any of the beneficiaries identified above considered a minor in the state in which they reside? Check one box only. ☐ Yes ☐ No

If you answered "Yes", please name the legally designated UTMA Custodian for all minor beneficiaries you have designated:

Custodian to Minor Beneficiaries:

Name: _____ Social Security Number (or FEIN/TIN # if a corporate entity): _____ - _____

Date of Birth (mm-dd-yyyy) (if an individual): _____ - _____ - _____ Address/City/State/Zip: _____

Phone: () - _____

Signature

- I understand that my dependents/family members cannot be enrolled for a coverage if I am not enrolled for that coverage.
- LIFE ONLY: I understand that life insurance coverage for a dependent/family member, other than a newborn child, will not take effect if that dependent/family member is confined to a hospital or other health care facility, or is home confined, or is unable to perform two or more Activities of Daily Living (ADL's).
- I understand that I must be actively at work or my elected coverage will not take effect until I have met the eligibility requirements (as defined in the benefit booklet.) This does not apply to eligible retirees.
- If coverage is waived and you later decide to enroll, late entrant penalties may apply. You may also have to provide, at your own expense, proof of each person's insurability. Guardian or its designee has the right to reject your request.
- I understand that plan design limitations and exclusions may apply. For complete details of coverage, please refer to the plan documents or enrollment materials. State limitations may apply.
- Your coverage will not be effective until approved by a Guardian or its designated underwriter.
- I hereby apply for the group benefit(s) that I have chosen above.
- I understand that I must meet eligibility requirements for all coverages that I have chosen above.
- Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements.
- I agree that my employer/planholder may deduct premiums from my pay if they are required for the coverage I have chosen above.
- I attest that the information provided above is true and correct to the best of my knowledge.

- "California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage."

Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

California law requires that insurers offering Accident, Cancer, Critical Illness and Hospital Indemnity policies or certificates must require that the person to be insured is covered for essential health benefits or minimum essential coverage as defined in federal law. If you do not have such essential health benefits or minimum essential coverage as defined in federal law, you may not enroll for Accident, Cancer, Critical Illness or Hospital Indemnity Coverage. By your signature below, you affirmatively attest that you, and any dependents to be covered, are covered by essential health benefits or minimum essential coverage as defined in federal law.

SIGNATURE OF EMPLOYEE/MEMBER X _____

DATE _____

Fraud Warning Statements

The laws of several states require the following statements to appear on the enrollment form:

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware, Indiana and Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Louisiana and Texas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinements in state prison.

Maryland : Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. (Does not apply to Life Insurance.)

New Mexico: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

Ohio: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Rhode Island: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Virginia: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.



**Bakersfield City School District
Premium Only Plan (POP) Enrollment Form**

EMPLOYER:	
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Employee Information (Please print clearly)

NAME:	First MI Last MI	SS#:	DATE OF BIRTH:
ADDRESS:	Street Address or P.O. Box		PHONE: ()
	City State Zip		

☐ Open enrollment

☐ New employee

Hours worked per week	Date of Hire:	Job Title:	Employment Status:
			☐ Full Time ☐ Part Time

I elect the following Salary Reduction Agreement:

☐ Election of **“Pre-Tax” Benefits Under the Salary Reduction Plan (premium amount is not subject to taxes)**

I hereby authorize and direct my employer to reduce my salary in the amount necessary to pay for my group medical, dental, and/or vision coverage with “pre-tax” dollars. Such reductions, considered as elective contributions under the Plan, will start with my first paycheck dated after the effective date of enrollment. I further authorize future adjustments in the amount of the salary reduction in the event the cost of coverage should change. I also understand that the purpose of this program is to allow employees to select their qualified benefits within the guidelines of the Internal Revenue Code. I understand that this election and the indication that a premium is to be paid does not provide insurance coverage. In most instances an application for insurance must also be completed.

☐ **“Post-Tax” Election (premium amount is subject to taxes)**

I elect to waive all pre-tax benefits under the Plan, but I elect to pay for my Health Insurance Benefits on an after-tax basis. Except for an allowable Change of Status event, I understand that I cannot elect pre-tax benefits until the next Open Enrollment period.

I understand that my POP contributions (if any) for medical, dental and vision coverage will be made on a “Post-Tax” basis unless I have checked the “Pre-Tax” option above. This election shall remain in effect until a subsequent election form is filed in accordance with the Plan. An eligible employee who elects not to participate or does not return the enrollment form will automatically be made on a “Post-Tax” basis.

I have read and agree to the terms of participation set forth in this Agreement.

Signature _____

Date: _____

Return the completed form to your employer.

Employer’s use only

Received and approved by authorized Qualified Employer: _____ Date: _____

Effective date of enrollment: _____

First payroll deduction date: _____