



BEDFORD CENTRAL SCHOOL DISTRICT

Health Insurance Benefits Enrollment Form

Email completed form and supporting documents to benefits@bcsdny.org or submit to the Payroll & Benefits Office.

EMPLOYEE INFORMATION

First Name:	Last Name:	MI:	Date of Birth:		
Address Line 1:	Address Line 2:	City:			
State:	Zip Code:	Social Security Number:	Phone Number:	Email Address:	Gender:
					M ☐ F ☐ X ☐
Marital Status: Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ If married, please enter spouse's insurance information on page 2.					
Job Title:	Hire Date:	Unit:			
		CSEA ☐ BTA ☐ BASA ☐ Admin. ☐ Non-Unit ☐			
Employee ID:					

*CSEA Dental requires an additional enrollment form.

If you currently have dental or vision coverage through another employer, please complete this section:

Employer Name:	Other Dental:
	☐
Name of Insurance Carriers and Policy Number(s):	Other Vision:
	☐

HEALTH BENEFIT OPTIONS

Type:	Level of Coverage:			
Medical ☐	Individual ☐	Family ☐	Waiving Coverage ☐	Already Enrolled; No Change ☐
Dental ☐	Individual ☐	Family ☐	Waiving Coverage ☐	Already Enrolled; No Change ☐
Vision ☐	Individual ☐	Family ☐	Waiving Coverage ☐	Already Enrolled; No Change ☐

Enter dependent information on Page 2.

- ☐ I authorize my employer to deduct the appropriate contribution from my earnings. ☐ Pre-Tax ☐ Post-Tax
- ☐ I understand that to qualify for coverage at a later date will require a change in family status or loss of coverage.
- ☐ I hereby authorize any provider of health care services, claim administrators, insurers, reinsurers, and others who have legitimate need for such information for the purpose of review, investigation, or evaluation of a claim, to supply to each other with information about my health status and healthcare services provided to me.
- ☐ I agree that a digital and/or photographic copy of this authorization is valid as the original.
- ☐ I have attached all necessary documentation for proof of employee and dependent eligibility.

Employee Signature:

Date

Benefits Administrator Signature:

Date

Effective Date of Coverage (Office Use Only):



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SPOUSE INSURANCE INFORMATION

Is your spouse employed? Yes ☐ No ☐

Is your spouse eligible for health benefits through an employer? Yes ☐ No ☐

Is your spouse covered under their employer's plan? Yes ☐ No ☐

Name & Address of Spouse's Employer:

Name of Spouse's Insurance Company:

Policy Number:

DEPENDENT INFORMATION

List spouse and any dependent child who will be covered under your health benefit option.

Dependent #1: First and Last Name Social Security Number Date of Birth Gender Relationship

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Address (if different)

Phone Number

Email Address

Is this dependent covered under any other health insurance? Yes ☐ No ☐

Dependent #2: First and Last Name Social Security Number Date of Birth Gender Relationship

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Address (if different)

Phone Number

Email Address

Is this dependent covered under any other health insurance? Yes ☐ No ☐

Dependent #3: First and Last Name Social Security Number Date of Birth Gender Relationship

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Address (if different)

Phone Number

Email Address

Is this dependent covered under any other health insurance? Yes ☐ No ☐

Dependent #4: First and Last Name Social Security Number Date of Birth Gender Relationship

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Address (if different)

Phone Number

Email Address

Is this dependent covered under any other health insurance? Yes ☐ No ☐

Dependent #5: First and Last Name Social Security Number Date of Birth Gender Relationship

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Address (if different)

Phone Number

Email Address

Is this dependent covered under any other health insurance? Yes ☐ No ☐

Dependent #6: First and Last Name Social Security Number Date of Birth Gender Relationship

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Address (if different)

Phone Number

Email Address

Is this dependent covered under any other health insurance? Yes ☐ No ☐

REQUIRED DOCUMENTS

-**Employee & all dependents:** government-issued ID (birth certificate, license, passport).

-**Spouse:** marriage certificate; medical coverage requires proof of joint financial obligation for all marriages over 2 years (eg. financial statements, bills, tax forms). *Please redact private data from financial documents.*