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 ☐

**CSEA Dental requires an additional enrollment form.*

Employee ID: ☐

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

Employer Name: | Other Dental: ☐ | Other Vision: ☐

Name of Insurance Carriers and Policy Number(s):

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

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

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

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

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

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

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.*