

Enrollment Form

Group Name: Bronxville Public School Employees' Benefit Trust

Member Information

All fields are required. Please Print.

Last Name	First N	lame	Social Security No.	Date of Birth				
Street Address	City		State	Zip				
Date of Hire	Effect	ive Date	Phone Number	Email				
Division Name:	01 - Teacher	02 - Clerical	O3 - Administrators	 O4 - Facilities & Maintenance 				
Please check one:	New Hire	New Hire Open Enrollment Life Status Change						
Coverage								
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Please check all that apply.

- Dental Benefit, Self Only No Cost
- Dental Employee, Plus One \$10 per pay

*If Life is chosen, please fill out the attached Guardian Beneficiary Designation/Change Form (Form GG-17).

- □ **Dental Employee, Plus 2+** \$18 per pay
- Vision Benefit, Self Only No Cost
- □ Vision Benefit, Plus 1+ \$2.50 per additional member per pay
- **Guardian Basic Life, Self Only \$50,000*** No Cost

Please complete the below for all to be covered under the Dental or Vision Plans, including yourself.

	Last Name	First Name	Social Security No.	Sex (M/F)	DOB MM/DD/YYYY	Plan Options (select all that apply)
Self						Both Included
Spouse						DentalVision
Child						DentalVision
Child						DentalVision
Child						DentalVision
Child						DentalVision
Child						DentalVision

Additional Documentation Checklist If applicable, please send in <u>copies</u> of the following documentation along with this completed form: Social Security Card(s) Death Certificates English translation for all foreign documents submitted Birth Certificate(s) Proof of Disability for all disabled dependents Marriage Certificate or PAID bursar's bill specifying QDRO/Divorce Documents semester/terms for all dependents aged 19-25 **Additional Coverage** Do you, or any of your dependents covered, also have coverage through another dental or vision plan? □ YES (Please check one) □ NO If YES, please complete the information in the chart below for each covered individual who is enrolled in the plan: **Other Coverage** Last Name **First Name** Date of Birth **Relationship to Employee** Signature **Member Signature** Date

Member Waiver Statement

I certify that I have been given an opportunity to participate in the Benefits Plan sponsored by the Bronxville Public School Employees' Trust. I understand fully the benefits available to me and I decline to participate in the plans being offered.

Waiver Signature	Date



Mail Completed Form To:

Bronxville School District Office

ATTN: Dawn Mulvey

177 Pondfield Road, Bronxville, NY 10708

Questions? You can call our Customer Service Department at (914) 250 – 0700.