DANIEL H. COOK
ASSOCIATES INC

Enrollment Form

Group Name: Bronxville Public School Employees' Benefit Trust

Member Information

All fields are required. Please Print.

Last Name	First Name	Social Security No.	Date of Birth

Street Address	City	State	Zip

Date of Hire	Effective Date	Phone Number	Email

Division Name: ☐ 01 - Teacher ☐ 02 - Clerical ☐ 03 - Administrators ☐ 04 - Facilities & Maintenance

Please check one: ☐ New Hire ☐ Open Enrollment ☐ Life Status Change

Coverage

Please check all that apply.

- ☐ **Dental Benefit, Self Only** – No Cost
- ☐ **Dental Employee, Plus One** – $10 per pay
- ☐ **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
- ☐ **Guardian Dependent Life*** - $1.60 per member per pay

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

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						☐ **Dental** ☐ **Vision**
Child						☐ **Dental** ☐ **Vision**
Child						☐ **Dental** ☐ **Vision**
Child						☐ **Dental** ☐ **Vision**
Child						☐ **Dental** ☐ **Vision**
Child						☐ **Dental** ☐ **Vision**

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Additional Documentation Checklist

If applicable, please send in copies of the following documentation along with this completed form:

- ☐ Social Security Card(s)
- ☐ Birth Certificate(s)
- ☐ Marriage Certificate or QDRO/Divorce Documents
- ☐ Death Certificates
- ☐ Proof of Disability for all disabled dependents
- ☐ PAID bursar's bill specifying semester/terms for all dependents aged 19-25
- ☐ English translation for all foreign documents submitted

Additional Coverage

Do you, or any of your dependents covered, also have coverage through another dental or vision plan? (Please check one)

- ☐ YES
- ☐ 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.