

## **Enrollment Form**

**Group Name:** Bronxville Public School Employees' Benefit Trust

Member Information										
All field	s are required. F	Please Print.								
Last Name Street Address		First Na	First Name City		ty No. Da	Date of Birth Zip				
		City			Zip					
Date of Hire		Effectiv	Effective Date		er Em	Email				
<b>Division Name:</b> 01 - Teacher 02 - Clerical 03 - Administrators 04 - Facilities & Maintenance										
Please	check one:	□ New Hire	☐ Open Enrollme	ent 🗆 Life	Status Change					
<ul> <li>□ Dental Employee, Plus One – \$10 per pay</li> <li>□ Dental Employee, Plus 2+ – \$18 per pay</li> <li>□ Vision Benefit, Self Only – No Cost</li> <li>□ Vision Benefit, Plus 1+ – \$2.50 per additional member per pay</li> <li>□ Guardian Basic Life, Self Only \$50,000* – No Cost</li> <li>□ Guardian Dependent Life* - \$1.60 per member per pay</li> <li>Please complete the below for all to be covered under the Dental or Vision Plans, including yourself.</li> <li>Last Name</li> <li>First Name</li> <li>Social Security</li> <li>Sex (M/F)</li> <li>DOB</li> <li>Plan Options</li> </ul>										
Self _			No.		MM/DD/YYY	Y (select all that apply)  Both Included				
Spouse _						□ Dental □ Vision				
Child						☐ Dental ☐ Vision				
Child _						□ Dental				
 Child						☐ Vision ☐ Dental				
Child						☐ Vision ☐ Dental ☐ Vision				
Child _						□ Vision □ Dental □ Vision				



Additional Documentation Checklist										
If app	plicable, pleas	e send in <u>copies</u> of t	he foll	owing documentation alor	ng with this co	omplete	d form:			
	Social Security Card(s)					ish translation for all foreign uments submitted				
	☐ Birth Certificate(s)			Proof of Disability for all disabled dependents						
☐ Marriage Certificate or QDRO/Divorce Documents			PAID bursar's bill specifying semester/terms for <u>all</u> 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										
	er Coverage	Last Name		First Name	Date of		Relationship to Employee			
Signature										
Men	nber Signatuı	Date								
Mem	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.										
Wai	ver 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.