bpa bestlife℠
Benefit Plan Administrators, Inc.

BENEFIT ENROLLMENT

Buena Vista City Public Schools

Choose one ○ New Employee ○ Open Enrollment ○ Qualifying Event	
Effective Date of Change:	**Location/ Department:**

Employee Information

Name (First I Middle I Last)		**Birth Date** (mm/dd/yyyy)	**Social Security Number**
Address		**City**	**State** / **Zip**
Email		**Home #**	**Cell #**
Gender ○ Male ○ Female	**Marital Status** ○ Single ○ Married ○ Divorced ○ Domestic Partner		**Hire Date** (mm/dd/yyyy)
Coverages Elected ○ Medical	**Coverage is for...** ○ Employee ○ Employee/Spouse ○ Employee Child(ren) ○ Family		
Plan Choice ○ $2000 Ded ○ $3000 Ded / HSA	*Includes Dental and Vision		

Dependent Information

Spouse/Domestic Partner

Name (First I Middle I Last)	Birth Date (mm/dd/yyyy)	Social Security Number	Gender	Action
			○ Male ○ Female	○ Add ○ Change ○ Waive ○ Terminate

Dependent #1

Name (First I Middle I Last)	Birth Date (mm/dd/yyyy)	Social Security Number	Gender	Action
			○ Male ○ Femalee	○ Add ○ Change ○ Waive ○ Terminate

Dependent #2

Name (First I Middle I Last)	Birth Date (mm/dd/yyyy)	Social Security Number	Gender	Action
			○ Male ○ Female	○ Add ○ Change ○ Waive ○ Terminate

Dependent #3

Name (First I Middle I Last)	Birth Date (mm/dd/yyyy)	Social Security Number	Gender	Action
			○ Male ○ Female	○ Add ○ Change ○ Waive ○ Terminate

Dependent #4

Name (First I Middle I Last)	Birth Date (mm/dd/yyyy)	Social Security Number	Gender	Action
			○ Male ○ Female	○ Add ○ Change ○ Waive ○ Terminate

○ **EMPLOYEE DECLINING MEDICAL**

I understand that I and/or my dependents, if any, waive any coverage and desire to participate in the plan at a later date. I/we may be considered a late enrollee and must meet the requirements defined in the Certificate of Coverage for the company's medical or dental plans. If I decline enrollment for myself or my dependents (including my spouse) because of other coverage, I may, in future be able to enroll myself or my dependents in this plan, provided I request enrollment within 31 days after the other coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption, placement for adoption of parting suit of adoption, I may be able to enroll myself or my dependent, provided I request enrollment within 31 days of the event.

○ **EMPLOYEE DECLINING DUE TO OTHER COVERAGE**

Employee Signature:	**Date:**

Please use another form to complete information for additional dependents.

Employee Acknowledgement and Authorization- I hereby apply for the group benefit(s) as indicated. I acknowledge that all entries are true and complete and that any mistatements or failure to report information may be used as the basis for cancellation of coverage for me and my dependent(s), if any, from the original effective date. Further, I authorize my employer to make the necessary payroll deduction of premiums for coverages I have elected.

Employee Signature:	**Date:**