Billing Acct# ________________________

EMPLOYEE APPLICATION and CHANGE FORM

* Comprehensive Medical * Dental * Vision * Short Term Disability * Long Term Disability * Life Insurance with Accidental Death & Dismemberment * Dependent Life Insurance

ALL Employees MUST Complete ALL Requested information on this application form in order to receive employer paid benefits. An incomplete application may need to be returned for completion which will delay the start of your coverage.

Club Information

Name of Club			**Applicants Job Title**		**Annual Salary**
Club Address			**Late Enrollee** ☐ Yes ☐ No	**Life Increase** ☐ Yes ☐ No **Over $100,000** ☐ Yes ☐ No	If transferring from another Club coverages eff First of the Month following day of transfer, provide Club name and the last day worked_____ / _____ / _____
City	**State**	**ZIP**			
Club Contact Person for Employee Benefits	**Club Contact Email**		**Reason for application:** ☐ New Enrollment ☐ Change Enrollment ☐ Waiver ☐ Other	☐ Qualifying Event (please complete date and reason) Event Date _____ / _____ / _____ ☐ Marriage ☐ Birth of Child ☐ Divorce	☐ Adoption ☐ Termination ☐ COBRA
Signature of Authorized Club Representative	**Club Contact Phone Number**				

Employee Information ☐ New Enrollee ☐ Change Enrollment

Name (Last, First, Middle Initial)			**Social Security Number**	**Gender** ☐ Male ☐ Female
Home Address		**Apt / Unit #**	**Date of Birth**	**Marital Status** ☐ Single ☐ Married
City	**State**	**ZIP**	**Date applicant was employed 30 or more hours per week** _____ / _____ / _____	

Comprehensive Medical Insurance ☐ Check Here if NOT Enrolling ☐ Change Enrollment

Select your Medical Plan

☐ Club Select ☐ Club Advantage ☐ Club Super Saver ☐ Club Premium HSA ☐ Club Choice EPO

☐ Club Choice ☐ Club Value (HRA) ☐ Club Basic HSA ☐ Club Select EPO

Select who should be covered

☐ Myself only ☐ Myself & My Spouse ☐ Myself & My Child(ren) ☐ Myself, My Spouse, and My Child(ren)

Dental Insurance ☐ Check Here if NOT Enrolling ☐ Change Enrollment

Select your Dental Plan

☐ Dental Plus Plan ☐ Dental Plan

Select who should be covered

☐ Myself only ☐ Myself & My Spouse ☐ Myself & My Child(ren) ☐ Myself, My Spouse, and My Child(ren)

Vision Insurance ☐ Check Here if NOT Enrolling ☐ Change Enrollment

Select your Vision Plan

☐ Vision Plus Plan ☐ Vision Plan

Select who should be covered

☐ Myself only ☐ Myself & My Spouse ☐ Myself & My Child(ren) ☐ Myself, My Spouse, and My Child(ren)

WAIVER OF COVERAGE SECTION: (Must be completed if employee and/or dependents waive medical, vision, dental, disability or life coverage) Applicant Section 7 must also be signed and dated.

Medical Coverage declined for (check all that apply):

☐ Myself ☐ Spouse ☐ Dependent(s)

Dental Coverage declined for (check all that apply):

☐ Myself ☐ Spouse ☐ Dependent(s)

Vision Coverage declined for (check all that apply):

☐ Myself ☐ Spouse ☐ Dependent(s)

Disability coverage declined for: ☐ Myself

Life coverage declined for: ☐ Myself

Reason for Declining Coverage (check all that apply):

☐ Covered by spouse's group coverage - Carrier name and ID Number_______________________

☐ Enrolled in other Insurance provided by my employer

☐ Carrier name and ID Number ____

☐ Enrolled in Individual coverage - ____

☐ Spouse covered by employer's group medical Coverage

☐ Medicare

☐ Other (Please explain)____

☐ No coverage

Covered Dependents

Relationship	Name (First, MI, Last if different) Dependent Social Security Number (Required)	Date of Birth	Gender	Check if married				Change Enrollment
☐ Spouse ☐ Domestic Partner	SS# _________ - _______ - _________	____ / ____ / ____	☐ Male ☐ Female	☐	☐ Medical	☐ Dental	☐ Vision	☐ Add ☐ Remove
Child	SS# _________ - _______ - _________	____ / ____ / ____	☐ Male ☐ Female	☐ Single ☐ Married	☐ Medical	☐ Dental	☐ Vision	☐ Add ☐ Remove
Child	SS# _________ - _______ - _________	____ / ____ / ____	☐ Male ☐ Female	☐ Single ☐ Married	☐ Medical	☐ Dental	☐ Vision	☐ Add ☐ Remove
Child	SS# _________ - _______ - _________	____ / ____ / ____	☐ Male ☐ Female	☐ Single ☐ Married	☐ Medical	☐ Dental	☐ Vision	☐ Add ☐ Remove
Child	SS# _________ - _______ - _________	____ / ____ / ____	☐ Male ☐ Female	☐ Single ☐ Married	☐ Medical	☐ Dental	☐ Vision	☐ Add ☐ Remove

*** Add additional Page for additional Children**

Short Term Disability Insurance

☐ I am enrolling

☐ I am NOT enrolling (Only if contributory)

Name ____________________________

Long Term Disability Insurance

☐ I am enrolling

☐ I am NOT enrolling (Only if contributory)

Basic Life Insurance / AD&D   *Must Complete Beneficiary Section of this Application*

☐ Employer Paid Basic Life Insurance and AD&D

☐ I am NOT enrolling (Only if contributory)

Employee Supplemental Life Insurance / AD&D ☐ **Enrollment Update**

Indicate amount of coverage desired (in $10,000 increments up to $500,000 - Not to exceed 5X Base Annual Earnings)

☐ I am enrolling   Amount $ ____________________

☐ I am NOT enrolling   For amounts over $100,000, evidence of insurability is required

Spouse Supplemental Life Insurance / AD&D (MUST HAVE EMPLOYEE SUPPLEMENTAL TO ENROLL) ☐ **Enrollment Update**

Indicate amount of coverage desired (in $5,000 increments up to $100,000 - Not to exceed employee's amount of coverage)

☐ I am enrolling   Amount $ ____________________

☐ I am NOT enrolling   For amounts over $30,000, evidence of insurability is required

Children Supplemental Life Insurance / AD&D   (MUST HAVE EMPLOYEE SUPPLEMENTAL TO ENROLL) ☐ **Enrollment Update**

Each child is covered for $10,000 (Not to exceed employee's amount of coverage)

☐ I am enrolling

☐ I am NOT enrolling

Late Enrollees - Life, STD and LTD Insurance Products

If you are applying for Life Insurance more than 30 days after the completion of the Waiting Period selected by your Club, you are a "Late Enrollee". As such, you will be required to complete a Evidence of Insurability (EOI) that will require approval by Guardian before coverage is granted. The Personal Health Statement can be obtained from Guardian or from www.BGCWA.com

Beneficiary Designation ☐ Beneficiary Change

I hereby make the following beneficiary designation for the distribution of benefits from the above applied for Life/AD&D coverage. (Give beneficiary name & relationship. If more than one person, indicate a percentage of benefit for each. If a Trust is named & the trustee is not a financial institution, forward a copy of the trust agreement.) The beneficiary for Spouse and/or Child Life Insurance shall be the employee, if surviving, or the Dependent's estate.

Beneficiary Names (s)	Percent	Address	City	State	Zip	Relationship
Primary						
Secondary / Contingent						
Secondary / Contingent						

IMPORTANT- Please Read Before Completing this application.

Eligibility

You are eligible to enroll for the BGCWA Insurance Trust Plans if you are actively employed by and regularly scheduled to work at least 30 hours per week on a consistent basis for the Boys & Girls Club application and you have satisfied the Waiting Period described below. Employees who work less than 30 hours per week and temporary or seasonal employees are not eligible to enroll for these Plans.

Waiting Period and Coverage Effective Date for New Employees

Your Club has selected a Waiting Period that must be satisfied before any of these insurance plans go into effect. The Waiting Period will be either 30-days or 60-days of continuous employment. Check with your Club's Insurance Representative to determine the applicable waiting period for your Club. During the Waiting Period you must meet the definition of an Eligible Employee shown above and be receiving your regular wage or salary from the Club. This Waiting Period will apply to all new employees unless the employee transferred from another Club that has the same or a similar Plan, and there was no gap between employments with the two Clubs. Then, with your new Club's approval, the Waiting Period can be waived. All coverages will be effective the first of the month following the applicable waiting period selected by your club. If you do not apply during within 30 days of your eligibility, your enrollment will be considered a late enrollment, and you will not be eligible until the next annual enrollment unless you have a HIPAA qualifying event or change in family status for Medical, Vision and Dental coverages ONLY. If you have a HIPAA qualifying event or a change in family status, you must enroll within 30 days of such event. In regards to Life/AD&D, late applicants will not be allowed into the plan for any reason if initially refused coverage. Supplemental Life AD&D annual enrollment period is only available to employees and dependents who currently have the coverage. You should discuss when your coverage will be effective with the Club's Insurance Representative.

Late Enrollment

An enrollment is considered a Late Enrollment if the enrollment application is not completed and submitted within 30-days after the Waiting Period. If you are a Late Enrollment your coverage effective date may be delayed until the next open enrollment period for Medical, Dental, Vision, STD and LTD. Any late Life Applicants may be required to fill out an EOI to be considered for coverage.

Coverage Selection

Check with your Club's Insurance Representative to learn which of the BGCWA plans are available to you. You can only enroll for plans that your Club has selected to offer to eligible employees and you may be responsible for paying a percentage of the premium through payroll deductions. If the Club pays 100% of the premium for any of the Plans, you must enroll for that Plan.

Coverage Changes

All Changes to coverage or terminations of coverage must be approved by your Club's Insurance Representative. If you are making changes to a previous enrollment election, please make sure to check the "change enrollment" box under each section you are changing.

During Annual Open Enrollment

If you are currently enrolled, and do not want to make any changes to you or your dependents' current coverage, you do not need to complete this enrollment form. You will automatically be enrolled with the same coverage you have now. During open enrollment, you only need to complete this form if you are making any changes to your election coverages, or if you are adding or removing dependents. Any Life/AD&D changes may require an EOI form to be completed before consideration of any increases in coverage.

Agreement

I acknowledge I have read the TERMS, and I accept its provisions as a condition of coverage. I represent that all answers are true and accurate to the best of my knowledge and I understand they will be relied upon by the Carrier in accepting this application. I understand misstatements or failures to report new medical information prior to my effective date may result in a material change to coverage or premium. Material misrepresentations or significant omissions in this application may result in increased premiums, benefits being denied or coverage(s) being recinded or cancelled.

I hereby request coverage under the Boys & Girls Club Workers Association Insurance Trust ("the Trust"). I understand that the insurance applied for shall become effective only after this application is accepted by the Trust, UMR and UnitedHealthcare for Health or Guardian if applying for Dental, Vision, Life Insurance and/or Long Term Disability Insurance. I represent that all statements and answers recorded on this application (and any attachments) are true and complete, and that I am currently an active employee consistently working at least 30 hours per week for the Boys & Girls Club organization named herein.

I authorize any hospital or other institution, physician, the Medical Information Bureau or any other person or organization who has attended or may attend or examine me (or my dependents, if applicable) or has any records or knowledge of our health, to furnish information as requested by the Trust.

I authorize my employer to deduct from my earnings any required contribution for the insurance to which I am, or may become entitled.

Signature of Applicant	Date
	_____ / _____ / _____

Return This Completed Form to:

BGCWA Insurance Trust c/o UMR

230 Lexington Green Circle, Suite 400
Lexington, KY 40503

Forms can be emailed to: bgc@umr.com

Forms can be faxed to: (859) 226-1726

Additional copies www.BGCWA.org

Questions about the BGCWA Insurance Trust, this application, or insurance plans. Please call 1-888-999-7718.

Dental, Vision, Life Insurance and Long Term Disability Insurance are underwritten by Guardian as of 2019

Medical and Short Term Disability Plans are Self Insured by the Boys and Girls Club Workers Association Insurance Trust