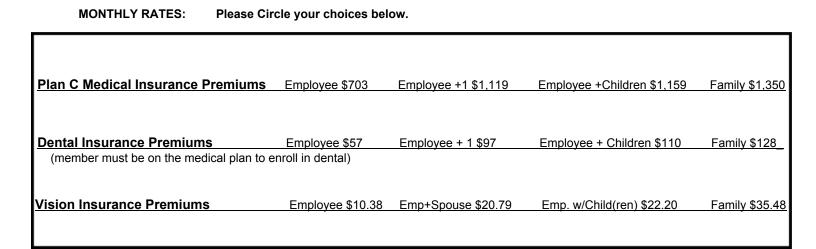
BILLINGS PUBLIC SCHOOLS 2020/2021 MEDICAL/DENTAL/VISION ENROLLMENT FORM

Rates Effective July 1, 2020

******Any employee with a change in eligible covered dependents must also complete a new BPS Benefits Enrollment Form.*******



NAME:		SOC. SEC. #:						
DIST. I.D.#:	PHO	NE:		F	ГЕ:	_		
Please Circle Your Unit:	BEA	BCEA	MPEA	ADMIN	CONTRACT			
PLEASE SELECT ONE PLAN	: MED		DEN	N	+ VIS	=	Total: \$	(A)
DISTRICT CONTRIBUTION (Th	ne contributi	ion is \$760) for full time	e teachers/ad	ministrators and sta	aff working over 20	hours a week) \$	(B)
	SUBT	RACT LI	NE B FRO	M LINE A.	LINE C = EMPL	OYEE COST EA	ACH MONTH: \$	(C)

Your premium cost (line C) will be deducted pre-tax. There is NO FEE for the pre-tax premium deduction. If you want your premium deducted after-tax, you must contact the Insurance Office and sign a "Premium Pre-Tax Declination Form".

With regard to my salary reduction agreement and my election of benefits, I understand that: *I may not change elections during the Plan Year unless there is a change in my family status. *The Administrator is authorized to adjust the amount of my salary reductions and benefits if it is necessary to satisfy certain provisions of the Internal Revenue Code or as a result of changes in premiums for benefits that are insured. *My election of salary reductions for medical/dental/vision benefits will remain in effect only for the Plan Year for which these elections are made. Failure to sign a new election form during the election period prior to each subsequent Plan Year will be considered an election to participate in the Plan for the Plan Year at the level of benefits selected for the previous year.

Authorizatio	on Signature	Date	Date		
	DECLINATION OF PARTICIPATION: I have been given the opportunity to participate in the Medical/Dental/Vis	ion Plan and have elected not to do so.			
BCEA, MPEA OR Part-time					
BEA ONLY	Signature for Declination of Coverage	Date			