Beech Grove City Schools

5334 Hornet Avenue
Beech Grove, IN 46107-2306
Phone (317) 788-4481
Fax (317) 782-4065
www.bgcs.k12.in.us

Welcome to Beech Grove City Schools!!

The attached packet contains important information regarding your insurance benefits.

Your medical, dental, and/or vision insurance coverage with Beech Grove Schools will start the first day of the month AFTER you have worked 30 days. For example, if you start any time in the month of July, your coverage starts September 1st.

Please complete and return the HSBT Anthem Enrollment form (medical, dental, and vision are on the same form). A Benefit Guide is attached for your review to help decide which plan is best for you and your family.

If you choose to WAIVE medical, dental, or vision coverage, the form needs to be returned with your name and the word WAIVE on the coverage you do not wish to take.

Additionally, you will receive a $100,000 life insurance policy paid for by Beech Grove Schools. Please complete the form with the beneficiaries you choose.

Because insurance is time sensitive, please submit the forms as soon as possible. If you have questions, please do not hesitate to contact Brian Garman (bgarman@bgcs.k12.in.us) or Eileen McManus (emcmanus@bgcs.k12.in.us) @ 317-788-4481.

HOOSIER SCHOOL BENEFIT TRUST - EMPLOYEE ENROLLMENT FORM

Hoosier School Benefit Trust Health & Wellness Center
Growing a healthy future together!

EMPLOYER'S Statement *(to be completed by employer)*
School Corporation: _____ **Group Number:** _____ Effective Date_____

No. of Hours Worked Per Week_____ Occupation _____Date of Hire/Re-Hire_____

Employer Authorization_____Date_____
ENROLLMENT CODE: [ ] New Hire [ ]New Enrollment for COBRA Qualifying Event
[ ] COBRA Coverage Exhausted[ ] Death of Spouse
[ ] Divorce/Legal Separation[ ] Employment Terminated
[ ] Employer/Group Plan Contribution Ceased [ ]Other
If Other, explain

COMPLETE THIS SECTION ONLY IF WAIVING COVERAGE- To Enroll, Skip to Section B

Section A – Waiver of Coverage *(This section must be completed for employee and / or any eligible dependent not enrolling the group health plan when initially eligible due to coverage elsewhere)*

Name of person waiving:	Coverage is provided by [ ] Spouse [ ] Parent [ ] No Coverage
Name of person waiving:	Coverage is provided by [ ] Spouse [ ] Parent [ ] No Coverage
Name of person waiving:	Coverage is provided by [ ] Spouse [ ] Parent [ ] No Coverage
Name of person waiving:	Coverage is provided by [ ] Spouse [ ] Parent [ ] No Coverage

I certify that I have been given an opportunity to apply for group health coverage through the Trust and I am declining as indicated above. I understand that I will be only be able to enroll in the future if I or my dependent(s) experience a HIPAA special enrollment event. I also understand that if I have a new dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents as long as I apply for coverage within 31 days of the event. It is important to note that only the employee, spouse and newly acquired dependent(s) receive special enrollment rights under this provision. Other dependents (such as siblings of a newborn child) are not entitled to special enrollment rights upon the employee's acquisition of a new dependent.

_____ **Date**_____
(Employee Signature) (Only if Waiving Coverage)

Section B – Coverages Requested:

MEDICAL: Plan 1/ Plan 2 _____ **Plan 3** _____ **Plan 4 (HSA)** _____ **Plan 5 (HSA)** _____

Employee Only _____ Employee and Spouse _____ Employee and Child(ren) _____ Family _____

DENTAL: Core Plan _____ **Enhanced Plan** _____

Employee Only _____ Employee and Spouse _____ Employee and Child(ren) _____ Family _____

VISION:

Employee Only _____ Employee and Spouse _____ Employee and Child(ren) _____ Family _____

Have you or other family members to be enrolled in this plan had other coverage in the past 2 years? ☐Yes ☐No
REMINDER: ***To avoid any pre-existing condition provision as required by this Group Health Plan, you will need to provide a Certificate of Creditable Coverage from your prior health carrier***

Section C – Employee / Application Information

First Name	Last Name	MI	Date of Birth	Sex ☐ M ☐ F	Social Security #	☐ Single ☐ Married ☐ Divorced

Home Address:	City:	State:	Zip:
Phone: E-Mail:			

If you are enrolling your spouse or dependent child(ren) the following documents must accompany your application:
For your spouse: A copy of your marriage certificate; ***AND*** documentation dated within the last 60 days establishing current relationship status such as a joint household bill, joint bank/credit account, joint mortgage/lease, or insurance policies. The document must list your name and your spouse's name, the date, and your mailing address. **For your child(ren):** A copy of the child's birth certificate, naming you as the child's parent, or appropriate adoption decree naming you as the adoptive parent; ***AND*** if applicable, a copy of a divorce decree granting full or joint custody (names of all parties must be included); ***OR*** if applicable, a copy of a court-issued Qualified Medical Child Support Order (QMCSO) or other court order where you are required to provide healthcare (names of all parties must be included). **For stepchild(ren):** A copy of the child's birth certificate, naming your spouse as the child's parent; ***AND*** A copy of your marriage certificate as proof of the dependent's relationship to the member; ***AND*** Documentation dated within the last 60 days establishing current relationship status such as a joint household bill, joint bank/credit account statement, joint mortgage/lease statement, or insurance policies. (The document must list your name and your spouse's name, the date, and your mailing address to validate member and spouse, not the child). **For Disabled Child(ren):** Same as above for other children AND a copy of the front page of your most recent filed federal tax return to confirm you claimed this dependent.

Section D – Spouse Information

First Name	Last Name	MI	Date of Birth	Sex	Phone Number:
				☐ M ☐ F	Social Security #:

Is your spouse employed?
[ ] Yes [ ] No If Yes, please provide name of employer:_____

Does your spouse have medical coverage through his/her employer?
[ ] Yes [ ] No

Section E – Family Information All Information is Required (*attach separate sheet if necessary*)

First Name:	Last Name:	MI	Date of Birth:	Relationship to EE: ☐ Son ☐ Daughter ☐ Other	Social Security #
First Name:	Last Name:	MI	Date of Birth:	Relationship to EE: ☐ Son ☐ Daughter ☐ Other	Social Security #
First Name:	Last Name:	MI	Date of Birth:	Relationship to EE: ☐ Son ☐ Daughter ☐ Other	Social Security #
First Name:	Last Name:	MI	Date of Birth:	Relationship to EE: ☐ Son ☐ Daughter ☐ Other	Social Security #
First Name:	Last Name:	MI	Date of Birth:	Relationship to EE: ☐ Son ☐ Daughter ☐ Other	Social Security #

Section F – Other Health Coverage

List yourself and any other family members to be enrolled in this plan who will be covered by other health coverage on this plan's effective date:

Provide name & address of insurance carrier:_____

Policyholder Name: _____Relationship to Employee:_____

Group/Account/Policy ID Number:_____ Effective Date_____ Termination Date:_____

If you and/or your dependent(s) are enrolled in Medicare or Medicaid, please complete the following:

Enrollee Name:	Medicare/Medicaid ID #	Medicare Part A Effective Date:	Medicare Part B Effective Date:

Reason for Medicare eligibility/entitlement:

By signature, I declare that the information provided is complete and correct. By electing coverage under this Plan, I also agree to have the applicable premium deductions made. I accept that I am responsible to notify my employer of any change that would make me or any dependent ineligible for benefits under the Trust group health plan.

_____ **Date:** _____

(Employee/Applicant Signature)

Your coverage is issued by a multiple employee welfare arrangement. The multiple welfare arrangement may not be subject to all of the insurance laws and regulations of Indiana. State guaranty funds are not available for your multiple employer welfare arrangement.

2023 HSBT RATES

PLAN	Deduction Code	Cost Per Month	Annual Cost	BGCS Pays Annually	Employee Pays Annually	Employee Owes 24 Pays	Employee Owes 18 Pays	
PLAN 1 / PLAN 2	$1500 / $3000		OPM $6000 / $10000					
Single	3H2SN	$ 844	$ 10,128	$ 7,325	$ 2,803	$ 116.79	NA	
Emp + Spouse	3H2ES	$ 1,989	$ 23,868	$ 13,254	$ 10,614	$ 442.25	NA	
Emp + Child(ren)	3H2EC	$ 1,677	$ 20,124	$ 11,708	$ 8,416	$ 350.67	NA	
Family	3H2FA	$ 2,373	$ 28,476	$ 15,113	$ 13,363	$ 556.79	NA	
PLAN 3	$2700 / $5400		OPM $8000 / $10000					
Single	3H3SN	$ 711	$ 8,532	$ 7,781	$ 751	$ 31.29	$ 41.72	3SNH3
Emp + Spouse	3H3ES	$ 1,685	$ 20,220	$ 14,687	$ 5,533	$ 230.54	$ 307.39	3ESH3
Emp + Child(ren)	3H3EC	$ 1,415	$ 16,980	$ 13,114	$ 3,866	$ 161.08	$ 214.78	3ECH3
Family	3H3FA	$ 2,030	$ 24,360	$ 16,994	$ 7,366	$ 306.92	$ 409.22	3FAH3
PLAN 4	$3800 / $7000		OPM $6900 / $11500		$1000 HSA over 20 pays			
Single	3H4SN	$ 568	$ 6,816	$ 6,601	$ 215	$ 8.96	$ 11.94	3SNH4
Emp + Spouse	3H4ES	$ 1,336	$ 16,032	$ 12,957	$ 3,075	$ 128.13	$ 170.83	3ESH4
Emp + Child(ren)	3H4EC	$ 1,136	$ 13,632	$ 11,816	$ 1,816	$ 75.67	$ 100.89	3ECH4
Family	3H4FA	$ 1,605	$ 19,260	$ 14,894	$ 4,366	$ 181.92	$ 242.56	3FAH4
DENTAL CORE								
Single	3DCSN	$ 33	$ 396	$ 350	$ 46	$ 1.92	$ 2.56	3SNDC
Emp + Spouse	3DCES	$ 72	$ 864	$ 350	$ 514	$ 21.42	$ 28.56	3ESDC
Emp + Child(ren)	3DCEC	$ 60	$ 720	$ 350	$ 370	$ 15.42	$ 20.56	3ECDC
Family	3DCFA	$ 102	$ 1,224	$ 350	$ 874	$ 36.42	$ 48.56	3FADC
DENTAL ENHANCED								
Single	3DESN	$ 46	$ 552	$ 350	$ 202	$ 8.42	$ 11.22	3SNDC
Emp + Spouse	3DEES	$ 99	$ 1,188	$ 350	$ 838	$ 34.92	$ 46.56	3EDDE
Emp + Child(ren)	3DEEC	$ 83	$ 996	$ 350	$ 646	$ 26.92	$ 35.89	3ECDE
Family	3DEFA	$ 140	$ 1,680	$ 350	$ 1,330	$ 55.42	$ 73.89	3FADE
VISION CERTIFIED								
Single	3VSNC	$ 7.40	$ 88.80	$ 88.80	$ -	$ -	NA	
Emp + Spouse	3VESC	$ 14.80	$ 177.60	$ 88.80	$ 88.80	$ 3.70	NA	
Emp + Child(ren)	3VECC	$ 15.84	$ 190.08	$ 88.80	$ 101.28	$ 4.22	NA	
Family	3VFAC	$ 25.30	$ 303.60	$ 88.80	$ 214.80	$ 8.95	NA	
VISION CLASSIFIED								
Single	3VSN4	$ 7.40	$ 88.80	$ -	$ 88.80	$ 3.70	$ 4.93	3VSN9
Emp + Spouse	3VES4	$ 14.80	$ 177.60	$ -	$ 177.60	$ 7.40	$ 9.87	3VES9
Emp + Child(ren)	3VEC4	$ 15.84	$ 190.08	$ -	$ 190.08	$ 7.92	$ 10.56	3VEC9
Family	3VFA4	$ 25.30	$ 303.60	$ -	$ 303.60	$ 12.65	$ 16.87	3VFA9

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2023 Health Savings Account
Payroll/Salary Reduction Agreement

Employee Name: _____

Date: _____

Please reduce my bi-weekly paycheck in the amount of: $_____ during the 2023 calendar year for a total of: $_____. Please have these dollars electronically deposited into (Bank Name): _____.

Account Number: _____

Routing Number: _____

(If bank information is the same as previous year, mark SAME across the lines.)

I understand the maximum 2023 contributions for an HSA are $3,850 (Single) and $7,750 (Family) and would include BOTH employee and employer contributions. If over the age of 55 there is an additional $1000 allowed to the maximum contribution.

I understand that Beech Grove City Schools will contribute $1000 into my HSA in increments of $50 for 20 payrolls in a calendar year. (The school corporation contribution will be based on a calendar year basis where the $1000 contribution begins with the 1st paycheck of a new calendar year annually and ends at the conclusion of the $1000 being contributed in full.) Employees need to provide an open HSA account at Teachers Credit Union (*or grandfathered HSA account if prior to October 2019*) no later than 12/31/2022 or forfeit the next month's contribution. There will be no retro contributions to an HSA due to the neglect of a Plan 4 participant not opening or providing a valid HSA account information

New HSA (Plan 4) enrollees, between April and October, will be entitled to $500, contribution through the current calendar year.

Employee Name Printed: _____

Employee Signature: _____

"Building a Culture of Excellence"

Beneficiary Designation Under Group Life Insurance Policy

Products and financial services provided by
American United Life Insurance Company®
a OneAmerica® company
One American Square, P.O. Box 6123
Indianapolis, IN 46206-6123
1-800-553-5318 Fax: 1-888-285-1565
www.employeebenefits.aul.com

OneAmerica®

IMPORTANT: PLEASE READ INSTRUCTIONS AND SAMPLE DESIGNATIONS ON REVERSE SIDE BEFORE COMPLETING FORM.

CHECK IF BENEFICIARY FOR: ☒ All Policies or ☐ Basic Life ☐ Supplemental ☐ Voluntary Term Life ☐ AD&D ☐ List Other _____

Group Policy/Participating Unit Number			
Name of Group Policyholder/Participating Unit	HOOSIER SCHOOL BENEFIT TRUST - BEECH GROVE CITY SCHOOLS		
Name of Insured Person			
Insured Person's SSN		Insured Person's Date of Birth	

Subject to the provisions of the policy, applicable laws, and the rights of any valid assignee of record with American United Life Insurance Company® (AUL), it is requested the beneficiary of any policy proceeds payable at the death of the Insured Person be as follows:

PRIMARY BENEFICIARY(S)

Name	*Relationship*	*Address*	*DOB*	*SSN*	*Percentage*
			Total[1]		0

CONTINGENT BENEFICIARY(S) IF THE PRIMARY BENEFICIARY(S) PREDECEASES YOU

Name	*Relationship*	*Address*	*DOB*	*SSN*	*Percentage*
			Total[2]		0

It is understood and agreed upon receipt of this beneficiary designation by AUL at its principal office, such beneficiary designation will become effective and shall relate back to the date this beneficiary designation is signed, but without prejudice to AUL on account of any payment made prior to the receipt of and acknowledgement of the validity of the beneficiary designation by AUL. AUL shall not be obligated to honor this beneficiary designation unless and until it has been received by AUL, acknowledged by the appropriate officer of AUL, and determined by AUL to comply with applicable law at the time a claim is made. This beneficiary designation supersedes and cancels all prior beneficiary designations by the Insured Person for the policy(s) indicated. If no beneficiary designation is named on any additional AUL coverage, the undersigned understands that this beneficiary designation will be used by AUL for any additional coverage.

The undersigned hereby declares that he/she has not been declared incompetent and no court order or laws prevent naming the above designee(s). It is agreed that AUL assumes no responsibility for the validity or effect of any purported beneficiary designation or transfer of rights under the policy. **The undersigned represents and warrants any information or documents provided to AUL by the undersigned prior to and after the date of the application for insurance and the facts and other matters contained in the foregoing are true and accurate to the best of the undersigned's knowledge and belief.** The undersigned understands and agrees: 1) any insurance coverage or benefits is contingent upon any statements made to AUL as being complete and correct and 2) benefits under any policy will be paid only if AUL decides the applicant is entitled to them under the policy.

Signature of Insured	*Signature of Witness* *(The Witness must have no interest in the policy/contract or be a named beneficiary)* N/A
Printed Name	*Printed Name*
Date	*Date*

Lack of Notice of Community Property Interest: If AUL has not previously received written notice of a community property interest and if the space for consent below is not signed by a person having such an interest, then AUL shall be entitled to rely upon its good faith that no such interest exists. AUL assumes no responsibility of inquiry regarding such interest and, in consideration of acknowledgement of this designation, the insured person listed above, for himself/herself and his/her estate, heirs, successors and assigns, agrees to indemnify AUL and hold it harmless from the consequences of acknowledging this beneficiary designation.

Spouse's signature and consent *(if applicable)*:[3] N/A Date _____

1 Total percentage must equal 100%. If percentages do not equal 100%, then benefits will be paid on a pro-rata basis, according to the percentages shown. If no percentages are shown, benefits will be distributed equally.

2 Total percentage must equal 100%. If percentages do not equal 100%, then benefits will be paid on a pro-rata basis, according to the percentages shown. If no percentages are shown, benefits will be distributed equally.

3 Spouse's signature is needed only if Insured/Beneficiary lives in a community property state which currently include AZ, CA, ID, LA, NM, NV, TX, WA and WI.

SAMPLE BENEFICIARY DESIGNATIONS

The beneficiary wording should be absolutely clear and without question as to whom the proceeds are to be paid. Listed below are sample beneficiary designations. Please note state laws may prohibit naming certain entities and individuals as a beneficiary. If you live in a community property state, you should obtain the signature of your spouse if your spouse will not be named as a primary beneficiary. Community property states currently include: AZ, CA, ID, LA, NM, NV, TX, WA and WI.

To ensure the correct individual or entity receives the benefits and the intended benefit amount, please provide the following:

- The beneficiary's social security number, tax identification number and date of birth.
- Distribution of proceeds should be shown in fractions or percentages if multiple beneficiaries are designated. Do not list dollar amounts as the amount of the insured's life benefit may change. If no distribution is shown, benefits will be divided equally among the living beneficiaries.

ACCEPTABLE BENEFICIARY DESIGNATIONS

1) **One Beneficiary –** State the full name and relationship to the insured.
   Sample: John Doe, husband
2) **Two Beneficiaries in Equal Shares –**
   Sample: Jane Doe and Mary Doe, cousins, in equal shares, or their survivors.
3) **Three or More Beneficiaries in Equal Shares –**
   Sample: Jane Doe, Mary Doe, and Richard Doe, cousins, in equal shares, or their survivors.
4) **Two Beneficiaries in Succession –** If the primary beneficiary dies, the second person named will receive the proceeds and is known as the contingent beneficiary.
   Sample: Martha Doe, wife, or, in the event of her death, Richard Doe, cousin.
5) **Three or More Beneficiaries in succession –** If the primary and secondary beneficiaries die, the third person named will receive the proceeds.
   Sample: Martha Doe, wife, or, in the event of her death, Richard Doe, cousin, or in the event of his death, Jane Doe, niece.
6) **One Beneficiary Followed by Two Beneficiaries in Equal Shares –**
   Sample: Martha Doe, wife, or, in the event of her death, Jane Doe and Mary Doe, cousins, in equal shares, or their survivors.
7) **One Beneficiary Followed by Three or More Beneficiaries in Equal Shares –**
   Sample: John Doe, husband, or, in the event of his death, Jane Doe, Mary Doe, and Richard Doe, cousins, in equal shares, or their survivors.
8) **Two Beneficiaries Shown in Percentages –**
   Sample: John Smith, cousin 40%, Sally Smith, aunt 60%.
9) **Two or More Beneficiaries Shown in Percentages –**
   Sample: Mary Doe, wife 50%, Jane Doe, cousin 25%, John Doe, cousin 25%.
10) **Estate –** Do not identify the name of the executor of executrix since this name may change as wills are updated.
    Sample: Estate of John Doe
11) **Custodian for Minor Children –** Please note any minor child beneficiary designation should nominate a custodian (i.e. bank, adult, trustee) followed by the words "as custodian for *(minor child's name)* under the *(child's residential state)* uniform transfers to minors act." This designation may avoid a court appointed guardianship for the payment of the death benefit.
    Sample: John Doe as custodian for Jimmy Smith under the Indiana Uniform Transfers to Minors act.
12) **Trust Agreement –** State the name of the trust and the date of the trust agreement.
    Sample: John Doe Trust dated _____ . Payment to trustee shall discharge the company.
13) **Wife or Unnamed Children –**
    Sample: Martha Doe, wife, or in the event of her death, our children, if any, or their survivors.
14) **Unnamed Children –**
    Sample: Children, if any, in equal shares, or their survivors.
15) **Beneficiary - No Relationship –**
    Sample: Mary Doe, friend
16) **To a Church or Organization –** It is preferable to indicate both the name and address and the wording "or its successors or assigns."
    Sample: Christ Lutheran Church or its successors or assigns
17) **Irrevocable Beneficiary –** This is acceptable, but not preferable, as the beneficiary must then approve any future beneficiary change.
    Sample: John Smith, husband, irrevocable beneficiary.
18) **Employee Unable to Sign –** This designation must contain the person's mark and be signed by two disinterested witnesses.

UNACCEPTABLE BENEFICIARY DESIGNATIONS

1) **Collateral assignments**, e.g. to banks, finance companies, etc. as creditors on a loan.
2) **The Employer**
3) **Funeral Homes**