INSURANCE PLAN AND TRUST FUND
LIMITED BENEFIT EMPLOYEE APPLICATION AND CHANGE FORM

Employee's name________________________ Sex: M F Date of birth ____________ Single Married

Address________________________ City ________________ ________ Zip ________

School________________________ Job title ________________________

Name of building (if different from above) ________________________

Grade level / subject taught ________________ Work email address ________________

Personal email address (necessary for applicant to view benefits) ________________________

Employee's phone number ________________ Date of employment ____________

Employee status: New school New hire Plan change Name/address change

Adding dependent(s) **Deleting dependent(s)** Dependent(s) name(s) ________________________

Reason for adding or deleting the dependent(s) ________________________

Effective date____ ____ ____ If termination, date participant notified of COBRA coverage ____________

Life insurance beneficiary's name________________________ SSN __________

Relationship________________________ Beneficiary's date of birth ____________

Beneficiary's address________________________ City ________________ State ________ Zip ________

Limited Benefits (includes dental, life, AD&D, and LTD):

Please choose one:

Single Dental Employee + Spouse Dental

Family Dental Employee + Child(ren) Dental

No dental. I am currently covered for dental under my spouse's or parent's employer plan.

My school does not offer dental coverage through CSI

Please choose one:

(If choosing family dental you must choose family life/AD&D)

Single Life, AD&D, and LTD

Family Life, Family AD&D and LTD for employee only

I have been given the opportunity to participate, but am refusing all Limited Benefits coverage. I understand that if my school has chosen short-term disability coverage, I am automatically enrolled in that benefit. (See eligibility on reverse side.)

If choosing Family Limited Benefit, please list each covered dependent **including spouse and all dependent children**:

1 Name ________________ Birthdate ____________ Sex: M F SSN ____________ Relationship ____________

2 Name ________________ Birthdate ____________ Sex: M F SSN ____________ Relationship ____________

3 Name ________________ Birthdate ____________ Sex: M F SSN ____________ Relationship ____________

4 Name ________________ Birthdate ____________ Sex: M F SSN ____________ Relationship ____________

By signing below, I authorize my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverage requested above. My signature below also verifies the accuracy of the information on this form. I understand that my enrollment, and that of any of my dependents, is contingent on meeting the eligibility and enrollment rules set forth in the documents that govern the programs in which I have requested enrollment. If I have declined enrollment for myself or any dependents, I understand that I may not change my enrollment elections until the next open enrollment period without a qualifying change of status event, and that some programs may also require satisfactory evidence of insurability at my expense.

Signed____ Date____________ SSN ____________

– continued on reverse side –

ELIGIBILITY:

a. Each school may choose the eligibility level for their employees. The choices are 50 percent, 62.5 percent, or 75 percent of a full-time position during a plan year (September 1–August 31). All educational employees are considered full time if they spend at least 1,000 hours in the classroom with students. All other employee are considered full time who work 40 hours per week (at least 2,000 hours in plan year).

b. 10 percent of all eligible employees may decline participation of all Limited Benefits coverage (Dental, Life/AD&D, and LTD) in addition to the employees and dependents who decline coverage because they are covered under a dental plan provided through a spouse's or parent's employer plan. Other exceptions may apply (government plans, etc.).

c. If your school participates in the short term disability plan, you will be automatically enrolled in that benefit.

PLEASE HAVE YOUR EMPLOYER COMPLETE.

Yearly salary__________________________School number 5439 - ____________

Forms may be submitted via **email** to:
aslachter@csionline.org

(or)

Forms may be submitted via **mail** to:
Christian Schools International
Attn: US Insurance
3350 East Paris Ave SE
Grand Rapids, MI 49512