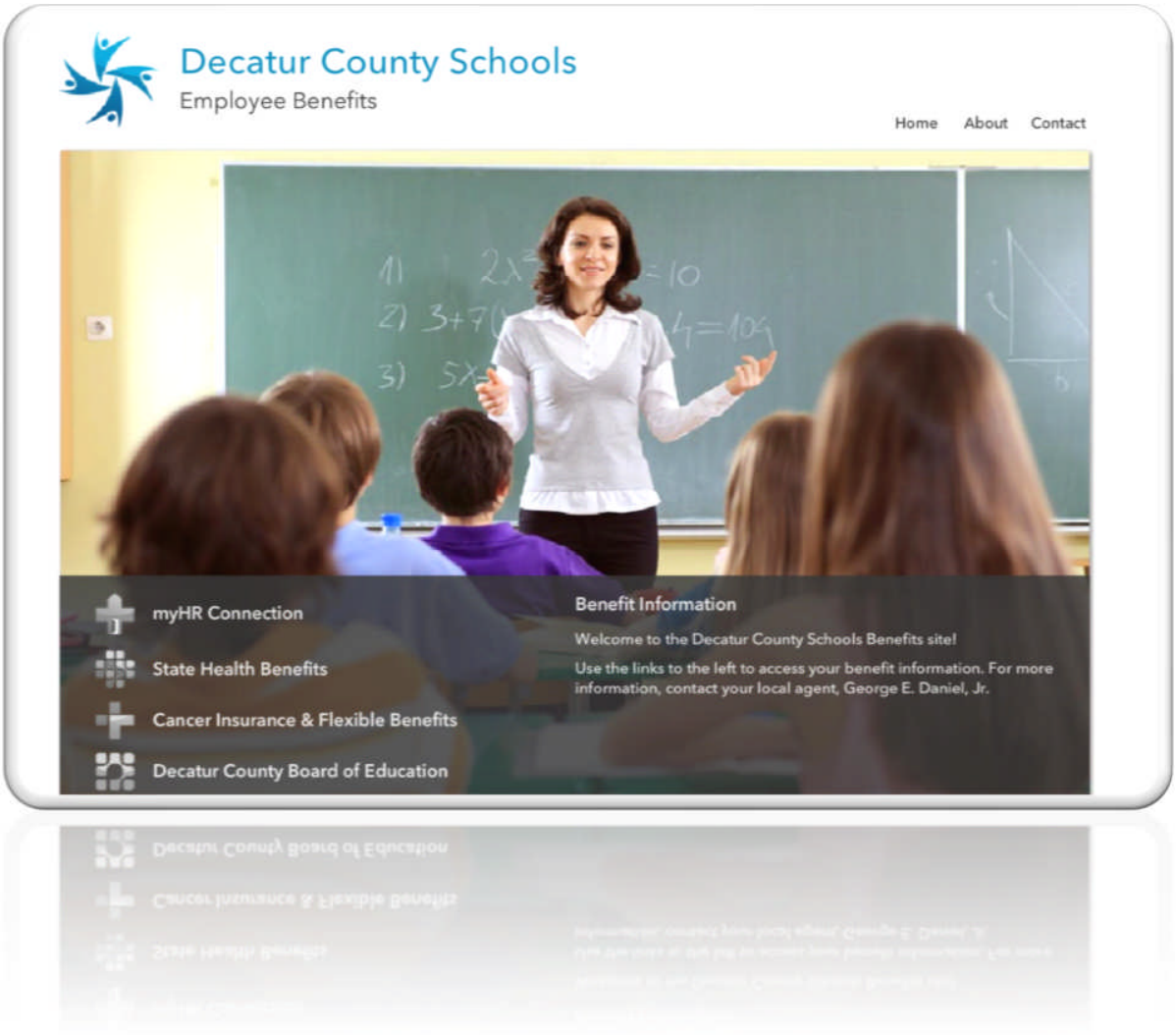
Decatur County Board of Education

New Employee Orientation



This booklet contains information on Insurance Benefits for you as a new employee of the Board of Education. The booklet will have a Summary Heading, Application, Evidence of Insurability (If Needed) and Summaries. Should you need additional information, you may access information on the web at www.dcboebenefits.com
You may contact me for more information on the products listed:

George E Daniel Jr
Danielhealth
119 Donalson Street
Bainbridge, Georgia 39817
Phone & Fax 229-246-3342 / Cell 229-416-7030
e-mail: dan@danielhealth.com

George E Daniel Jr CIC, CPIA

George E Daniel Jr CIC, CPIA
119 N Donalson Street
Bainbridge, Georgia 39817

Phone 229-246-3342
Fax 229-416-4999
Cell 229-416-7030
e-mail: dan@danielhealth.com
Web: www.danielhealth.com

New Employees
Decatur County Board of Education
100 N West Street
Bainbridge, Georgia 39817

RE: New Employee Orientation

Welcome!

Congratulations on being a New Employee for the Board of Education! The Board offers some important Employee Benefits that you should consider adding at this time as a new employee. The Benefits are needed and affordable! All benefits will be payroll deducted, and many are pre-taxed.

Included in this package of Employee Benefits are the following Benefits, Summaries & Applications.

Group Term Life
Accidental Death & Dismemberment
Universal Life – Permenant Life Insurance
Short Term Disability
Long Term Disability
Dental Reimbursement
Vision Insurance

If you have any additional suggestions or comments, please contact me at 229-246-3342, or e-mail me at dan@danielhealth.com & my Cell is 229-416-7030. You may find additional information on the web at www.dcboebenefits.com

Sincerely,

George E Daniel Jr CIC, CPIA
Certified Insurance Counselor

New Employee
Orientation
Insurance Benefits Package

You may enroll in our employee benefits program for the Decatur County Board of Education now as a new employee. Many of these benefits are Guaranteed Issue, regardless of your past medical condition. However, once you pass this time, then insurance benefits may be offered during open enrollment, but may be underwritten based on your medical condition and you may be denied coverage

In this Package

Group Term Life
AD&D Insurance
Universal Life

Dental Reimbursement
AVESIS VISION

Short Term Disability
Long Term Disability

See WWW.DCBOEBENEFITS.COM for more information

Agent
George E Daniel Jr CIC, CPIA
Danielhealth
119 Donalson Street
Bainbridge, Georgia 39817
229-416-7030 Cell / 229-246-3342 Work

Employee Benefits – Visit: www.dcboebenefits.com or www.mydcboebenefits.com

Forms & Applications are available on this web address under forms - Open Enrollment Forms
Contact me at Phone: (229) 246-3342 & (229)-416-7030 Cell • e-mail: georgeedanieljr@gmail.com

Group Term Life Insurance

You may apply for new coverage or change your current coverage. You may increase your coverage by $10,000 guaranteed Issue, up to a Max Amount of $150,000 each year. You may also increase your spouse if covered by $10,000 a year up to the same amount as the employee. If you change the amount over the $10,000, an evidence of insurability form will be needed on each insured. Children may be added for $15,000 for $3.00. Please complete a new application for all changes. The new app will take president over the older one. Term Life Insurance is Mortality Insurance, Inexpensive, Now Portable to Age 70. Please consider purchasing Universal Life Insurance for longer Life Insurance Needs.

Accidental Death & Dismemberment Insurance (AD&D)

AD&D Insurance is guaranteed Issue on the Employee up to $500,000, and you may purchase up to 50% Coverage on your Spouse of what you carry as the employee. Premiums are inexpensive at .03 per thousand ex: $100,000 = $3.00 Month Please complete an application for changes or new coverage.

Universal Life Insurance

Universal Life Insurance is a form of Whole Life Insurance that is permanent. You can keep this policy at your current age and rates are for life. You may purchase $25,000; $50,000 ; $75,000 or $100,000 guaranteed issue up to Age 55, then simplified issue after that age. Please complete a new application for each member to be insured, Employee, Spouse & Children. A child Term Rider is available, Please ask! This Policy Includes a **Long Term Care Insurance Rider**, **Accelerated Death Benefit** and a **Safety Benefit** at no additional cost. You can keep this policy at group rates after you leave the school system.

Short Term Disability

Coverage starts for Disability on the 1st Day in the Hospital Confinement and also for an accident, 7 days for a sickness. Coverage is up to 6 months. Maternity is covered, and coverage applies for a full 12 months if you are in school or not, Includes Summer and Holidays. You may increase coverage by $100.00 per month Benefit guaranteed issue up to a max benefit of $2,000 a month, See chart with application for salary, benefits and premiums. Complete a new application to make any changes.

Long Term Disability

Coverage starts with a 6 month waiting period and will provide coverage up to Age 65 or longer if still working at age 65. Coverage Benefit is based on 66 2/3 of your gross salary. Premiums are inexpensive and based on salary. Once you have the benefit it tracks with your income, no other changes are needed. Complete the Card LTD Application and EOI for coverage.

(Continue on Back)

Dental Reimbursement

Reimbursement will be made up to $750.00 a person per contract period. Benefits are paid at 100% of the 1st $150.00, then 50% of the next $1,200.00. Premiums are $10.00 for single coverage and $30.00 for family coverage. Please complete a new application for any changes or new applicants. Benefits are paid weekly, Children need proof of school after age 19 to continue to be covered.

Vision Insurance

Avesis offers members discounted Eye Exams at $10.00, then glasses and contacts are discounted to the employee up to $200.00 per member. Other benefits are also available at an Avesis Network Eye Center. Dr Aldridge's Office & Walmart are local Eye Care Avesis Members. Coverage is inexpensive at $5.95 for single employee, $10.38 for Emp + 1 & $15.28 for family coverage. See the application and brochure for more details.

Sample Rates

Group Term Life Rates

$50,000	$ 8.00
$100,000	$16.00
$150,000	$24.00

Children

$15,000	$ 3.00

AD&D Rates

$100,000	$ 3.00
$300,000	$ 9.00
$500,000	$15.00

Spouse

$ 50,000	$ 1.50
$150,000	$ 4.50
$250,000	$ 7.50

Universal Life
Age 35

$25,000	$ 21.00
$50,000	$ 35.00
$100,000	$ 65.00

Age 45

$ 25,000	$ 30.00
$ 50,000	$ 84.00
$100,000	$108.00

Dental

Single	$ 10.00
Family	$ 30.00

LTD
Salary Based

$ 10,000	$ 3.33
$ 30,000	$ 9.99
$ 50,000	$ 16.66

Vision

Single	$ 5.95
Single + 1	$ 10.38
Family	$ 15.28

Short Term Disability

$500.00	$10.30
$1,000	$ 20.60
$2,000	$ 41.20
$2,500	$ 51.50
$3,000	$ 61.80

GROUP TERM LIFE

You may enroll in Group Term Life Insurance Employees – Guaranteed Issue up to $150,000 or up to 7 Times Salary Maximum

Premium is .16 per $1,000 of Benefit

Examples
$50,000 = $8.00 Pre-Taxed
$100,000 = $16.00
$150,000 = $24.00

Premium for your Spouse is the same as Employee Guarantee on Spouse is $20,000, but can apply for more on a Simplified Basis!

Children up to Age 26 may get $15,000 for $3.00 a month (All Legal Children)

Complete Application

Agent
George E Daniel Jr CIC, CPIA
229-416-7030 Cell / 229-246-3342 Office

*** AD&D is also available under separate application ***

Group Policy # K10078800

Decatur County Board of Educati

Enrollment Application

Return To: Plan Administrators, Ltd
580 Hazard Avenue
Enfield, CT 06082

Please print or type all information. Complete and sign at the bottom.

EMPLOYEE Name - LAST	FIRST	MIDDLE INITIAL	Social Security No.	Group Number	Division	Class
				0560	1	ALL

Home Address – City	State	ZIP	Sex	Date of Birth	Marital Status
			MALE FEMALE		

Your Occupation	Employer Name	Hire Date	Hours worked per week	Annual Salary
	Decatur County Board of Educati			

Primary Beneficiary (For Employee Life)	Social Security #	Relationship	Date of Birth

Contingent Beneficiary	Social Security #	Relationship	Date of Birth

Life Coverage Requested:

Check Employee Coverage Desired

Coverage Amount	Monthly Rates
$20,000	
$30,000	
$40,000	
$50,000	
$60,000	
$70,000	
$80,000	
$90,000	
$100,000	
$_____	

Spouse/Dependent Coverage
$,000/$,000

If applying for Spouse/Dependent Coverage, complete section below:

Name (Last, First, MI)	Social Security #	Date of Birth	Sex (M/F)
Spouse			
Child(ren)			

If dependent children are full-time students in college, vocational or trade school or graduate school please complete the following:

Child(ren)	Name of School	# or Hours

To decline coverage, complete this section. ☐ **Employee** ☐ **Spouse/Dependent**

I understand that I have been given an opportunity to participate in the group insurance plan offered by my employer I am refusing the term life insurance coverage indicated above for which I am required to contribute. If I and/or my dependents wish to participate at a later date, I understand that coverage(s) may be limited and satisfactory evidence of insurability may be required.

Reason for refusing coverage:_____

Employee's signature:_____ Date:_____

I Hearby request to be insured and authorize deductions, if any, from my compensation for my share of the cost of the benefits to which I may be entitled under group policy(ies) issued to the employer listed above. I understand that if I am not actively at work as defined in the policy on the date my coverage would otherwise become effective, my insurance will not begin until the day I meet the policy definition actively at work.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties.

Employee's signature: _____Date:_____

Administered by
Plan Administration Ltd
580 Hazard Ave · Enfield CT 06082
860-272-1135

HUMANA
Specialty Benefits

Products are underwritten by:
Kanawha Life Insurance Company,
a Humana Company

Guaranteed Issue - Employee up to $150,000; Spouse $20,000 Ch

Group Term Life Insurance Evidence of Insurability

Kanawha Insurance Company

KMG AMERICA
KANAWHA INSURANCE COMPANY

Kanawha Insurance Company (Hereafter the "Company")

Person applying for insurance (each applicant should complete a separate form): ☐ Employee ☐ Child ☐ Spouse ☐ Member

Applying for: ☐ Supplemental Amount $_____ ☐ Late Entry

Name of Applicant (Last Name, First Name, Middle Initial)

Address City State ZIP

Daytime Telephone Number Date of Birth Place of Birth Height Weight

Name of Employee/Member

Name of Group Policyholder Policyholder Group No.

Answer each of the following "Yes" or "No." For each **"Yes"** answer, **circle** the applicable item(s) and give full details in the space provided on Page 2.

1. Have you ever been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or AIDS related conditions or tested positive for the HIV (AIDS) virus? ☐ Yes ☐ No

2. Within the past 5 years have you been diagnosed or treated by a member of the medical profession for a heart attack, heart surgery, heart disease, uncontrolled high blood pressure (unstable readings or frequent medication changes), stroke, transient ischemic attack (TIA), cancer, leukemia, Hodgkin's Disease, lymphoma, diabetes, nervous or mental disorder, kidney disease, renal failure, blood disorder, lupus, liver disease, lung disorder, emphysema, alcohol or drug abuse, multiple sclerosis, cerebral palsy, amyotrophic lateral sclerosis (ALS/Lou Gehrig's Disease), spina bifida, sickle cell anemia, or chronic hepatitis? ☐ Yes ☐ No

3. Have you:
   a. within the past 5 years seen any physician, clinic, or hospital for treatment of any condition not specifically asked about in Question 2? ☐ Yes ☐ No
   b. within the past 3 years been medically advised to have any diagnostic test, hospitalization, or surgery, which was not completed? ☐ Yes ☐ No
   c. within the past 12 months used cigarettes or any other tobacco products? ☐ Yes ☐ No

4. Are you presently taking medication(s)? ☐ Yes ☐ No

   List medications _____

5. During the past 2 years have you been unable to work by reason of disability for 3 or more consecutive weeks? If "Yes," give dates and reasons on Page 2. ☐ Yes ☐ No

* Note - Only Use if you are applying for more than the Guaranteed

Return to: Plan Administration, Ltd.
580 Hazard Avenue
Enfield, CT 06082
Phone: 860-272-1135
Fax: 860-272-1136

Indicate details of the "Yes" answers from Page 1.

Question No.	Nature of Illness or Injury	Date of Last Treatment	Describe Remaining Effects	Name/Address of Physician or Hospital

6. Do you intend to travel or reside outside of the United States? ☐ Yes ☐ No
   If "Yes," provide length of stay, locations, and number of travels per year.

   _____

7. Are you engaged in any occupational or recreational activities, such as: flying as a pilot, co-pilot or crew member, sky diving, skin or scuba diving, motorized racing, ballooning or hang gliding? ☐ Yes ☐ No
   If "Yes," provide details:

   _____

I acknowledge that, to the best of my knowledge and belief, each of the statements above are true and complete. The statements and answers given in this application and any statements made to the medical examiner will be the basis of any insurance issued. I agree that no insurance shall take effect unless this Evidence of Insurability is approved by Kanawha Insurance Company. In the event of such approval, the insurance will become effective as provided in the policy.

Authorization and Acknowledgement Statement

By this form (or photocopy of it), which is valid for 30 months from the date shown below, I authorize any licensed physician, medical practitioner, clinic, hospital, or other medical or medically-related facility, insurance company, the Medical Information Bureau, or other person, organization, or institution that has any records or knowledge of me, my spouse or my child for whom insurance application is made, or my health, my spouse's or my child's health, to give to Kanawha Insurance Company, or its reinsurers, any such information in order to determine eligibility for coverage and to testify as to such information, all to the extent permitted by law.

I acknowledge that I have been furnished the MIB Disclosure Notice and the Notice to Applicant.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

_____ _____

Signature of Applicant Date

AD&D

ACCIDENTAL DEATH & DISMEMBERMENT

You may enroll in the New AD&D Insurance Now!
Employees – Guaranteed Issue up to $500,000
Spouse may purchase up to 50% of Employee
Premium is .03 per $1,000 of Benefit

Examples

Employee	Spouse
$ 100,000 = $3.00	$ 50,000 = $1.50
$ 200,000 = $6.00	$ 100,000 = $3.00
$ 300,000 = $9.00	$ 150,000 = $4.50
$ 400,000 = $12.00	$ 200,000 = $6.00
$ 500,000 = $15.00	$ 250,000 = $7.50

Complete Application Attached

George E Daniel Jr CIC, CPIA

229-416-7030 Cell / 229-246-3342 Office

Buy-Up AD&D Enrollment Application

Return To: Plan Administrators, Ltd
580 Hazard Avenue
Enfield, CT 06082

Please print or type all information. Complete and sign at the bottom.

EMPLOYEE Name - LAST	FIRST	MIDDLE INITIAL	Social Security No.	Group Number	Division	Class

Home Address – City	State	ZIP	Sex	Date of Birth	Marital Status
			☐ MALE ☐ FEMALE		

Your Occupation	Employer Name	Hire Date	Hours worked per week	Annual Salary
	Decatur County Board of Educaton			

Primary Beneficiary (For Employee Life)	Social Security #	Relationship	Date of Birth

Contingent Beneficiary	Social Security #	Relationship	Date of Birth

Life Coverage Requested:

☐ Check Employee Coverage Desired

Coverage Amount	Monthly Rates
☐ $100,000	$3.00
☐ $200,000	$6.00
☐ $300,000	$9.00
☐ $400,000	$12.00
☐ $500,000	$15.00
☐ Check Spouse Coverage Desired	
☐ $50,000	$1.50
☐ $100,000	$3.00
☐ $150,000	$4.50
☐ $200,000	$6.00
☐ $250,000	$7.50

If applying for Spouse Coverage, complete section below:

	Name (Last, First, MI)	Social Security #	Date of Birth	Sex (M/F)
Spouse				

AD&D coverage can not exceed $500,000 in total including that currently in force.
Spouse coverage can not exceed 50% of employee amount.

Spouse Beneficiary:

To decline coverage, complete this section. ☐ **Employee** ☐ **Spouse/Dependent**

I understand that I have been given an opportunity to participate in the group insurance plan offered by my employer I am refusing the term life insurance coverage indicated above for which I am required to contribute. If I and/or my dependents wish to participate at a later date, I understand that coverage(s) may be limited and satisfactory evidence of insurability may be required.

Reason for refusing coverage:_____

Employee's signature:_____ Date:_____

I hereby request to be insured and authorize deductions, if any, from my compensation for my share of the cost of the benefits to which I may be entitled under group policy(ies) issued to the employer listed above. I understand that if I am not actively at work as defined in the policy on the date my coverage would otherwise become effective, my insurance will not begin until the day I meet the policy definition actively at work.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties.

Employee's signature: X_____ Date:_____

UNIVERSAL LIFE

You may enroll in Universal Life Now!
Employees – Guaranteed Issue to $100,000
to Age 55, Simplified Issue after 56
Build Long Term Life Insurance

Insured, Spouse & Children
$25,000 / $50,000 / $100,000
Keep Life Insurance After you Retire!
Premiums based on Age & Amount & S/NS

Permanent Life Coverage

See www.dcboebenefits.com for more information

Complete Application Attached

Agent
George E Daniel Jr CIC, CPIA
229-416-7030 Cell / 229-246-3342 Office

SYMETRA
FINANCIAL

SYMETRA.
FINANCIAL

Symetra Financial – Sample Premiums based on Age & Amount of Coverage, showing Monthly Non Smoker Premiums Using Unisex Rates (Same for Male or Female) Rates May Change.

Sample Coverage & Premiums for Universal Life

Insured's Age	$25,000	$50,000	$75,000	$100,000
25	$15.00	$24.00	$35.94	$42.00
26	$16.00	$26.00	$38.14	$45.00
27	$16.00	$27.00	$39.50	$47.00
28	$17.00	$28.00	$40.95	$49.00
29	$17.00	$29.00	$42.50	$51.00
30	$18.00	$30.00	$44.12	$53.01
31	$19.00	$31.00	$45.85	$56.00
32	$19.00	$32.00	$47.68	$58.06
33	$19.30	$33.08	$49.62	$60.78
34	$19.99	$34.44	$51.66	$63.63
35	$20.21	$35.00	$52.50	$65.00
36	$21.43	$37.58	$56.37	$70.25
37	$22.20	$39.37	$59.05	$74.00
38	$23.02	$41.24	$61.86	$77.92
39	$23.89	$43.22	$64.82	$82.02
40	$25.82	$47.48	$67.94	$86.32
41	$25.82	$47.48	$71.22	$90.82
42	$26.88	$49.78	$74.67	$95.55
43	$28.00	$52.21	$78.32	$100.52
44	$29.18	$54.76	$82.14	$105.73
45	$29.69	$56.05	$84.07	$108.50
46	$31.71	$60.14	$90.20	$116.50
47	$33.08	$62.98	$94.47	$122.08
48	$34.53	$65.99	$98.98	$128.00
49	$36.08	$69.19	$103.79	$134.27
50	$37.74	$72.54	$108.89	$140.93
51	$39.51	$76.20	$114.30	$148.00
52	$41.38	$80.02	$120.03	$155.48
53	$43.38	$84.07	$126.10	$163.40
54	$45.49	$88.36	$132.54	$171.80
55	$46.57	$90.63	$135.94	$176.25

Based on the current interest rate, the above premium will keep the policy in force. Interest rate fluctuations and possible cost of insurance changes may impact the amount of premium needed.

The above quote provides the estimated premium based on the information provided and is not an offer for insurance. Eligibility for coverage and target premium amount are subject to the underwriting of the application.

Symetra Life Insurance Company's Symetra Universal Life policy form L-9994 10/07 (in most states) is underwritten by Symetra Life Insurance Company, Bellevue, WA 98004

Premium expense charge and monthly expense load will vary by issue age, gender and rate class. Rates from Employee & Spouse are the same, Children may have their own policy or may be included for a $5,000 Term Rider at a small additional premium.

LIFE INSURANCE — SIMPLIFIED APPLICATION
PART I LUC-128 10/07

Mail completed application to:
Symetra Life Insurance Company

PO Box 84068
Seattle, WA 98124-9918

Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200, Bellevue, WA 98004-5135

PROPOSED INSURED INFORMATION

Insured Name First Middle Last	☐ Male ☐ Female	Soc. Sec. No.
Address Street/PO Box City State Zip		
Daytime Phone Evening Phone		
Occupation	Annual Income	State or Foreign Country of Birth
Height / Weight / Driver's License #		Date of Birth
Owner if other than Proposed Insured	Soc. Sec./Tax ID:	
Owner Address Street/PO Box City State Zip		

Insurance Needed For:
☐ Debt Obligations ☐ Family Income Needs ☐ Business Needs ☐ Other _____

BENEFICIARY NAME Relationship		Primary	Contingent	%
		☐	☐	
		☐	☐	
		☐	☐	
Any living children born of this marriage or legally adopted to share equally		☐	☐	

COVERAGES

Plan Choice

☐ 10-Year Term ☐ 20-Year Term ☐ Other _____

☐ Universal Life Plan (UL) Death Benefit Option (please select one option) ☐ Level ☐ Increasing

X Universal Life X

Amount of Life Insurance Coverage $_____

Supplemental Benefits ☐ Insured Children's Benefit: No. of units _____ Maximum units 5 (1 unit = $1,000)

☐ Waiver Benefit (UL Only) ☐ Other _____

PERSONAL HISTORY

	Yes	No
1. In the past 12 months, have you used any form of tobacco or nicotine based products?	☐	☐
2. In the past 12 months, has the Proposed Insured been admitted or advised to be admitted to a hospital except for normal childbirth?	☐	☐
3. Is the Proposed Insured currently disabled or unable to perform all the regular duties of his/her occupation?	☐	☐
4. In the past 10 years, has the Proposed Insured had a motor vehicle violation of driving under the influence of alcohol or drugs, had their license suspended, or been convicted of reckless driving, participated in aviation activities as a pilot or crew member, or engaged in parachuting, mountain and/or rock or ice climbing, hang-gliding, or racing of any motor driven vehicle or craft?	☐	☐
5. In the past 10 years, has the Proposed Insured tested positive for or been treated for the Human Immunodeficiency Virus (HIV) infection or been diagnosed by a member of the medical profession as having Acquired Immunodeficiency Syndrome (AIDS) caused by HIV infection or other sickness or condition derived from such infection?	☐	☐

6. In the past 10 years, has the Proposed Insured been hospitalized or received medical advice for:

	Yes	No		Yes	No
Heart disease or disorder	☐	☐	Major depression, bipolar disorder,		
Cancer (not including basal cell)	☐	☐	schizophrenia, or suicide attempt	☐	☐
Leukemia	☐	☐	Stroke or transient ischemic attack	☐	☐
Kidney disease or disorder (not kidney stones)	☐	☐	Lymphom a	☐	☐
Pancreas disease or disorder	☐	☐	Diab etes	☐	☐
Crohn's disease or ulcerative colitis	☐	☐	Liver disease (not hepatitis A)	☐	☐
Central nervous system disease or			Respiratory disease or disorder (not asthma)	☐	☐
disorder (such as MS, epilepsy, paralysis)	☐	☐	Alcohol or drug dependency	☐	☐

REMARKS

Please explain any yes answer to questions 2-6 under Personal History, including doctor names, addresses and dates and treatments. Special Note: If someone other than the Proposed Insured will own this policy, provide name, social security number or Tax I.D. here.

Effective Date:

REPLACEMENT

7. Do you have any other existing life insurance policies or annuity contracts with this or any other company? (in force or applied for) — Yes ☐ No ☐

Company	Face Amount	Policy Type	Annual Premium

8. To the best of the applicant's knowledge, will the policy applied for replace any existing life insurance policy or annuity, or is any part of the premium to be paid by policy loan, or cash value on insurance presently in force? (if yes, attach state replacement disclosure) — Yes ☐ No ☐

9. If the policy being replaced has cash value or surrender charges, please provide this information in the remarks section.

AGENT

10. Does the applicant have any existing life insurance policies or annuity contracts with this or any other company? — Yes ☐ No ☐

11. To the best of your knowledge, will this insurance replace or change any existing life insurance or annuity? — ☐ ☐

12. If replacing, how does this policy better serve the applicant's needs?

PAYMENT AND TEMPORARY INSURANCE

Premium Payment Frequency:

☐ Monthly Automatic Bank Draft (EFT)* ☐ Other Payroll Deduction Payment with Application $_____

For future pa yments taken by EFT, please complete the f ollowing information. *M arking this b ox a uthorizes us to a utomatically deduct from your checking or savings account by electronic funds transfer (EFT).

Name on Account	☐ Checking ☐ Savings	Bank Name
Routing Number	Account Number	Draft Date (date cannot be the 29th, 30th or 31st)

If your face amount is $2 50,000 or les s and you answered "no" to questions 2-6, you will be covered under the temporary insurance agreement if a check is collected for the initial payment or if you sign up for initial payment by EFT.

AUTHORIZATION TO RELEASE PERSONAL INFORMATION

I here by a uthorize and re quest a ny me dical c are provider, p harmacy, pharm acy b enefits m anager, in dividual employer, i nsurance company, reinsuring company, medical examiner, government unit, con sumer reporting agency, or oth er person or orga nization, and MIB, Inc., to disclos e an y and all medic al information, n on-medical i nformation, emplo yment informati on, a nd i nsurance i nformation they h old concerning me , to the emplo yees, ag ents, or attorne ys of S ymetra Life Insuranc e Companies.* This disclos ure a uthorization will permit employees, agents or reinsurers of S ymetra Life Ins urance Companies to view, copy, be furnished copies, share, or be given details of all such information described above including, but not limited to, mental and physical condition, evaluation, diagnoses, treatment, prognoses, prescription re cords, a nd/or t oxicology results; specifically to inc lude drug, alco hol use, mental ill ness, psychiatric treat ment or diagnosis, testing a nd/or treatment of th e Human Immunodeficiency Virus (HIV) an d/or other se xually-transmitted dise ases. S ymetra Life Ins urance Companies obtain medical information only in connection with specific products or cl aims. Symetra Life Insurance Companies will not use or shar e personally identifiable med ical information for any pur pose other than th e u nderwriting or a dministration of your p olicy, claim or account. I und erstand th at the inform ation obtained purs uant to this Aut horization will be us ed for th e pur pose of verif ying, e valuating, negotiating, an d other p ertinent leg al us es, with res pect to m y app lication for i nsurance, or cla im under a pol icy of ins urance. T his authorization will expire at the end of the contestability period of any insurance policy issued in reliance on the records obtained through this authorization or twenty-four (24) months after the date of signing this authorization. The individual signing this authorization has the right to revoke an authorization in writing, except to the extent that action has been taken in reliance on the authorization, or during a contestability period. A written statement revoking this authorization delivered to S ymetra Life Ins urance Companies at their usual business addresses will rev oke thi s authoriz ation. An y cop y of this authoriz ation shall h ave the same aut hority as the original. I also understa nd that my representative, or I have a right to receive a copy of this authorization upon request

I, the Owner, certify under the penalties of perjury that (1) the num ber shown in Applicant Info section is m y correct taxpayer identification number, and (2) I am not subject to backup withholding.

I (we) agree t hat al l the stat ements a nd answers r ecorded o n this application ar e tru e an d com plete to the best of m y/our be lief and knowledge and shall form a part of an y policy iss ued. I hav e also read the Temporary Life Insurance Agreement. (Maximum Coverage is $250,000)

Any person who, with intent to defraud or knowing he/she is facilit ating a fraud a gainst an insurer, submits an a pplication or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

I acknowledge this insu rance policy was not a p rerequisite to receiv ing credit, prop erty or ser vices from th e bank and that th e amount of insurance I am apply ing for ma y not meet my c omplete fin ancial needs. I ha ve receiv ed information both orally and in writing stating that this insuran ce product is not a de posit or other obligation o f, or guaranteed b y, the bank or an affiliate of the bank and that the insurance product is not insured b y the Federal Deposit Insurance Corporation (FDIC) or any other agency of the United States, or an affiliate of the bank.

Signed this _____, at _____, State of _____
Date City State

_____	George E. Daniel, Jr.
Printed Name of Proposed Insured	Print Name of Writing or Authorized Agent
_____	_____
Signature of Proposed Insured (Age 15 or older)	Signature of Writing or Authorized Agent
_____	229-246-3342 41-3502
Signature of Applicant/Owner ** if other than Proposed Insured	Agent Phone Agent Stat Number
	dan@danielhealth.com
	Agent Email

Branch Name _____ Branch # _____ 7-Digit Cost Center # _____ Rep ID # _____

* Symetra Life Insurance Companies include: Symetra Life Insurance Company, Symetra National Life Insurance Company.
** If applicant is corporation/partnership, a corporate officer/partner other than proposed insured must sign.

SHORT TERM DISABILITY

You may enroll in Short Term Disability Now!
Employees – Guaranteed Issue up to $2,000 a month
0 day Waiting Period for Accidents & Hospital
7 Day Waiting Period for Sickness

Benefits last up to 6 Months!
Increase by $100 a year up to Guaranteed Benefit
Premiums based on the Selected Benefit
(See Chart on Application)

See www.dcboebenefits.net for more information

Complete Application Attached

Agent
George E Daniel Jr CIC, CPIA
229-416-7030 Cell / 229-246-3342 Office

Group Short Term Disability

Short Term Disability Plan for employees which provides coverage with a (0) day waiting period for accidents & (7) day waiting period for sickness. Benefits last up to 6 months. Coverage begins for 1st Day in Hospital

Remember that you choose the level of benefits that you want. These do not increase automatically with salary; you must increase these or make changes during open enrollment each year. Guaranteed Issue now to $2,000 for New Employees. $100 Increase allowed per year guaranteed up to $2,000 (Higher Benefits Available)

If Your Gross Annual Salary is At Least	You Are Eligible for a Benefit of this amount	Monthly Premium Deduction
$ 1,800.00	$ 100.00	$ 2.06
$ 3,600.00	$ 200.00	$ 4.12
$ 5,400.00	$ 300.00	$ 6.18
$ 7,200.00	$ 400.00	$ 8.24
$ 9,000.00	$ 500.00	$10.30
$10,800.00	$ 600.00	$12.36
$12,600.00	$ 700.00	$14.42
$14,400.00	$ 800.00	$16.48
$16,200.00	$ 900.00	$18.54
$18,000.00	$1,000.00	$20.60
$19,800.00	$1,100.00	$22.66
$21,600.00	$1,200.00	$24.72
$23,400.00	$1,300.00	$26.78
$25,200.00	$1,400.00	$28.84
$27,000.00	$1,500.00	$30.90
$28,800.00	$1,600.00	$32.96
$30,600.00	$1,700.00	$35.02
$32,400.00	$1,800.00	$37.08
$34,200.00	$1,900.00	$39.14
$36,000.00	$2,000.00	$41.20
$37,800.00	$2,100.00	$43.26
$39,600.00	$2,200.00	$45.32
$41,400.00	$2,300.00	$47.38
$43,200.00	$2,400.00	$49.44
$45,000.00	$2,500.00	$51.50
$46,800.00	$2,600.00	$53.56
$48,600.00	$2,700.00	$55.62
$50,400.00	$2,800.00	$57.68
$52,200.00	$2,900.00	$59.74
$54,000.00	$3,000.00	$61.80
$55,800.00	$3,100.00	$63.86
$57,600.00	$3,200.00	$65.92
$59,400.00	$3,300.00	$67.98
$61,200.00	$3,400.00	$70.04
$62,000.00	$3,500.00	$72.10
$64,800.00	$3,600.00	$74.16
$66,600.00	$3,700.00	$76.22
$68,400.00	$3,800.00	$78.28
$70,200.00	$3,900.00	$80.34
$72,000.00	$4,000.00	$82.40
$73,800.00	$4,100.00	$84.46
$75,600.00	$4,200.00	$86.52
$77,400.00	$4,300.00	$88.58
$79,200.00	$4,400.00	$90.64
$81,00.00	$4,500.00	$92.70
$82,800.00	$4,600.00	$94.76
$84,600.00	$4,700.00	$96.82
$86,400.00	$4,800.00	$98.88
$88,200.00	$4,900.00	$100.94
$90,000.00	$5,000.00	$103.00

ASSURANT EMPLOYEE BENEFITS

UNION SECURITY INSURANCE COMPANY (the "Company")

Administrative Office: One Riverfront Plaza, Westbrook, ME 04092-9700

EMPLOYEE ENROLLMENT FORM FOR GROUP DISABILITY

This Area for Agent or Plan Administrator Use Only.

Group Number:	Requested effective date of coverage: The first day of
28712	_____ Month, _____ Year

To enroll, please type or print in dark ink and return to your Agent or Employer. Keep a copy for your records. Any changes must be initialed by the Applicant.

Last Name	First Name	Middle Initial	Birth Date (MM/DD/YY)	Gender ☐ M ☐ F	Social Security No.

Home Address Number/Street	City	State	Zip

Home Phone Number	Employer Name	Your Work Location/Site
( )	DECATUR COUNTY BOE	Bainbridge, Ga

Date of Hire	Occupation	Annual Income $	Your scheduled work hours per week
			40

Will the coverage applied for with this enrollment application:

a. *replace* any existing disability income? ☐ Yes ☐ No

b. *be in addition* to any existing disability income? ☐ Yes ☒ No X

All applicants review the following guidelines and complete this section to request coverage.

- Amounts must be elected according to the Rate Schedule provided.
- Depending on the amount of coverage you elect, you may be required to complete the Health Questions.
- Consult your agent for details concerning maximum amounts of insurance and Evidence of Insurability requirements.

Coverage	(N)ew (I)ncrease (D)ecrease (C)ancel	Monthly Benefit Amount	If (I) Or (D), My Prior Coverage Was	Monthly Premium / Rate
Short-Term Disability ☐ Yes ☐ No X **Elimination Period** 0/7 **Max. Period of Payment** 6 Months				
Long-Term Disability ☐ Yes ☐ No **Elimination Period** N/A **Max. Period of Payment**				

Number of Salary Deductions/Year 12

I authorize the Payroll Department to deduct the required premium from my salary for the insurance coverage for which I am applying. These authorized deductions may be made at intervals mutually agreed upon by my employer and the Company, and are to be paid to the Company when due. I understand I am responsible for paying any premium due for which the Payroll Department cannot make a regularly scheduled deduction. I understand that in order to revoke this authorization, I must notify my Payroll Department in writing to cancel the premium deductions and abide by any rules specified by the employer's benefit plan and/or by law.

The insurance applied for shall be in force as of the date described in the certificate provided the Company approves my application without any modifications as to the plan amount or premium. If the application is approved with any such modification, the insurance shall not take effect until the certificate has been delivered to and accepted by me and furthermore shall not take effect if there has been a change in the health of any person to be insured as stated since the date of application.

All of the information on this application is complete, correct and true to the best of my knowledge and belief.

Dated at: Bainbridge (City) Georgi (State) On: _____ (Month Day Year)

_____ Signature of Employee

_____ Printed Name of Employee

Health Questions *(For Employees Applying for Amounts of Insurance over the Guaranteed Issue Limit, Enrolling Late, Increasing Coverage, or Enrolling again after having Cancelled Coverage)*

Last Name	First Name	Middle Initial	Social Security No.

Please answer the following questions.
If you answer "YES" to any questions, please provide details in REMARKS below.

Height _____ Weight _____

1. Have you gained or lost 10 or more pounds during the past 12 months? ☐ Yes ☐ No
   If "YES", how much? _____
2. Have you within the past 5 years: ☐ Yes ☐ No
   a. Received or been advised to receive any medication, treatment, surgery, therapy, testing, observation, or consultation by a physician, surgeon or other health care provider (including psychologist, counselor, dentist, chiropractor, osteopath, etc.) in any clinic, hospital, sanitarium, health resort or any other health related facility?
   b. Used any illegal drugs? ☐ Yes ☐ No
3. In the past 5 years, have you had, been treated for or been advised to seek treatment for persistent cough, fatigue or swollen glands, pneumonia, chest discomfort, muscle weakness, unexplained weight loss of ten pounds or more, patches in mouth, skin lesions, prolonged night sweats, visual disturbance or recurring diarrhea, fever or infection? ☐ Yes ☐ No
4. Have you ever been diagnosed as having acquired immunodeficiency syndrome (AIDS)? ☐ Yes ☐ No
5. Are you pregnant? ☐ Yes ☐ No
6. Have you ever had, been medically diagnosed, treated or been advised to seek treatment for: Arthritis; back, neck or joint disorder; asthma; emphysema or lung disorder; cancer or tumors; diabetes; alcohol, cocaine or drug abuse; high blood pressure; stroke or heart disease or disorder; depression; psychological counseling; mental, nervous or eating disorder; seizures; or immune system disorder? ☐ Yes ☐ No

   "Disorder" is defined as a disease, illness, injury and/or condition differing in any way from the usual or normal state and/or structure.

Name, address and telephone number of personal physician _____

_____

REMARKS – If you answered "YES" to any health question above, please provide details below. Should you require additional space, please use a separate sheet of paper and attach it to this form.

Question No.	First Name	Description of illness, injury, or pregnancy, medication or treatment	Duration (dates) & No. of episodes	Residual effects/ results	Name and address of attending physician or hospital (*include zip code*)

If Answering Health Questions, the Employee signature is required on page 3 of this form.

IMPORTANT NOTICE TO APPLICANTS ---- PLEASE READ CAREFULLY

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION FOR INSURANCE UNDERWRITING PURPOSES
(excluding psychotherapy notes)

(This authorization complies with the HIPAA Privacy Rule)

I authorize any licensed physician, any other medical practitioner or provider, pharmacist, hospital, clinic, other medical or medically related facility, federal, state or local government agency, insurance or reinsuring company, consumer reporting agency or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, and any non-medical information about me, to give any and all such information to authorized representatives of Disability Reinsurance Management Services, Inc. (Disability RMS), and the Company, *excluding psychotherapy notes*, and including, but not limited to, any other mental or psychiatric records, medical, dental and hospital records (including psychiatric, alcohol, and drug abuse, and **HIV/AIDS*** information) which may have been acquired in the course of examination or treatment. I understand that the information obtained by use of this authorization will be used by Disability RMS, the Company, and the above-described representatives to evaluate my application for disability and/or life insurance and may be redisclosed to any organization or person employed by or representing Disability RMS or the Company solely to assist with this purpose. I give my permission to Disability RMS, the Company or its reinsurers to release any information to other life insurance companies as I may come in contact with. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA's Privacy rules, or any other federal or state law.

This authorization will remain in effect a maximum of six (6) months from the date of the signature below. A photocopy of this authorization is as valid as the original. I understand that my authorized representative or I have the right to request and receive a copy of this authorization and the information to which it pertains.

I understand that I or my authorized representatives have the right to revoke this authorization by notifying Disability RMS in writing. However, such revocation is not effective to the extent that Disability RMS and/or the Company have relied previously upon this authorization for the use or disclosure of my protected health information pursuant to this authorization, and as a result, may be the basis for denying insurance or during a contestability period under applicable law. Failure to sign this authorization may impair our ability to evaluate my application and as a result may be a basis for denying my application for disability and/or life insurance coverage.

NOTICE REGARDING MEDICAL INFORMATION BUREAU AND INSURANCE INFORMATION PRACTICES

Information regarding your insurability will be treated as confidential. The Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such company, the Bureau, upon request will supply such company with the information in its file. Upon receipt of a request form from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is: Post Office Box 105, Essex Station, Boston, Massachusetts 02112, Telephone number: (617) 426-3660.
You have the right to gain access to and request correction of information contained in our files. However, we will not disclose information which relates to a claim or to a civil or criminal proceeding. If you wish to receive a more detailed explanation of our information practices, including a description of access and correction rights as well as circumstances under which non-authorized disclosures or personal information may be made, please contact Senior Vice-President, Underwriting and Administration, 2323 Grand Boulevard, Kansas City, MO 64108-2670.

I have read the NOTICE REGARDING MEDICAL INFORMATION BUREAU AND INSURANCE INFORMATION PRACTICES and the AUTHORIZATION TO OBTAIN MEDICAL INFORMATION FOR INSURANCE UNDERWRITING PURPOSES and I have made a copy of my application for my records. To the best of my knowledge and belief, all statements made on this application are true and complete. I understand that my application for insurance will be accepted or declined on the basis of these statements.

Unless specific state language is provided below, and except for Virginia residents, the following general fraud notice applies: *Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.*

Dated at: Bainbridge (City) Geor (State) On: ____/____/____ (Month / Day / Year)

Signature of Employee

Printed Name of Employee

LONG TERM DISABILITY

You may enroll in Long Term Disability Now!
Employees – Guaranteed Issue
Benefits are 67 2/3 % of Gross Salary
6 Month Waiting Period for Accidents & Sickness

Benefits last up to Age 65 & More
Premiums based on Salary
Coverage tracks Salary
Inexpensive Coverage

See www.dcboebenefits.net for more information

Complete Application Attached

Agent
George E Daniel Jr CIC, CPIA
229-416-7030 Cell / 229-246-3342 Office

Example Premiums for Long Term Disability

Your Long Term Disability Coverage is based on Salary, Once you purchase this coverage, you will not need to update it as it will follow your salary at 67 2/3% of Gross Salary with a 6 month waiting period for Accident & Sickness. Coverage will last up to Age 65, and further if you continue to work after age 65

To estimate your monthly deduction for Long Term Disability Coverage, please see below:

ANNUAL SALARY _____ X 66.66 % Divided by 12 = _____

Total _____ X .60 = _____ Move decimal 2 places to left

Total Premium : _____

Example

Annual Salary: $35,000 X 66.66% = 23,331.00 Divided by 12 = $1,944.25 X .60 =

1167.00, move decimal 2 places to the left = $11.67 Month Payroll Deduction

PLAN ADMINISTRATION, LTD GROUP ENROLLMENT CARD	Group Policy No. 0560	Cert No.	Social Security (Cert) No.

APPLICANTS Last Name (Please Print)	First Name	Initial	State	Class	SEX M F

APPLICANTS RESIDENCE	Street Address	City	State	Zip
				ALL

Name of Employer, Association or Union	Location
Decatur County Board of Education	Bainbridge, Georgia 39817

Salary $ Hrs. Worked	Union Non-Union	Date of Birth	Mo.	Day	Year	Occupation	Title

Date Employed Full Time	Mo.	Day	Year	Date Eligible	Mo.	Day	Year	Life & AD&D

Other Spouse Benefits	A&S	LTD	Dependent	Sup\Vol
	N/A	YES	N/A	N/A

N/A

BENEFICIARY DESIGNATION (Please Print)	First Name	Initial	Last Name	Relationship

I (1) REQUEST THE GROUP INSURANCE COVERAGE FOR WHICH I AM OR MAY BECOME ELIGIBLE (2) AUTHORIZE DEDUCTIONS FROM MY PAY OR DUES FOR MY SHARE OF THE COST, IF ANY, AND (3) DESIGNATE THE BENEFICIARY NAMED ON THIS CARD TO RECEIVE THE PROCEEDS; IF ANY, PAYABLE IF I DIE.

_____ X _____

Date Signed — Applicants Signature

Reliance Standard Insurance Con

Please do not fill in Salary, We will get it from the Boarc

DENTAL REIMBURSEMENT

You may enroll in Dental Reimbursement Now!
Employees – $10.00
Family – $30.00

Pays 100% of the 1st $150.00 then
50% of the next $1,200.00

REIMBURSEMENT FOR DENTAL EXPENSES: the table above shows the reimbursement from Decatur County Board of Education for Dental Expenses. The Benefit Policy Year is from January 1st through December 31th of each year.

Your Dental Reimbursement checks will be processed weekly, picking up on Tuesday and paying by Thursday of each week.

If you have your claim form and receipt in the central office on Monday, your claim check will be processed and paid by Thursday of the same week.

See www.dcboebenefits.net for more information

Complete Application

Agent
George E Daniel Jr CIC, CPIA
229-416-7030 Cell / 229-246-3342 Office

Decatur County Board of Education

Dental Reimbursement Plan Enrollment Election From

Employee Name: _____

Employee SS#: _____/_____/_____ **Employee D/O/B:** _____/_____/_____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home/Cell Phone: _____ **Work Phone:** _____

School/Work Location: _____ **E-Mail:** _____

Please choose the appropriate option below:

Employee/Single Coverage	Family Coverage	I choose to NOT enroll in the
$10.00	$30.00	DCBOE Dental Reimbursement
☐	☐	☐

If you elected family coverage, please list dependents below:

Spouse: _____ **D/O/B:** _____/_____/_____ **SS#:** _____/_____/_____

Dependent: _____ **D/O/B:** _____/_____/_____ **SS#:** _____/_____/_____

Dependent: _____ **D/O/B:** _____/_____/_____ **SS#:** _____/_____/_____

Dependent: _____ **D/O/B:** _____/_____/_____ **SS#:** _____/_____/_____

Dependent: _____ **D/O/B:** _____/_____/_____ **SS#:** _____/_____/_____

Dependent: _____ **D/O/B:** _____/_____/_____ **SS#:** _____/_____/_____

HIPPA: This form is used to authorize, the DCBOE, and its agents, or employees, to use or disclose your protected Health Information (PHI) to the administrator, or employee's to administrate our DR Dental Plan. We will use your information for service, billing questions, claims, letters, and to provide your benefits to you. This authorization is at the request of the individual and will expire as of your termination of employment with the DCBOE. You have the right to revoke this authorization at any time by giving written notice of my revocation to the County Office. I understand that revocation of this authorization will not affect any action you took in reliance on this authorization before you received my written notice of revocation. I have had full opportunity to read and consider the contents of this authorization, and I understand that by signing this form, I am confirming my authorization of the use/or disclosure of my protected health information as described in this form.

Do you have other Dental Insurance? Yes ☐ No ☐

If yes, name of other company: _____

Address: _____

City: _____ State: _____ Zip: _____

Policy Number: _____

I elect or decline coverage offered to me by the DCBOE Dental DR Plan as marked above during open enrollment. I hereby authorize my employer, until this authorization is revoked by written notice, to deduct each month from any earned or accrued wages due me, the amount applicable to the coverage I have selected. I hereby certify that the above information and any attachments thereto are true and correct. I understand misrepresentation or falsification will subject me to penalties and possible legal action.

Employee Signature: _____ **Date:** _____/_____/_____

AVESIS – VISION

INSURANCE

You may enroll in Avesis Vision Insurance Now!
Employee = $ 5.95
Employee + 1 = $10.38
Employee & Family = $15.28

$10 Vision Eye Exams
Benefits 12/ 24 Months
In-Network Discounts

Avesis Vision: **See the brochure for Vision for more details**

In Network Benefits - * $200.00 Average retail when choosing frames and lenses package!
LASIK Surgery – Members receive a one-time allowance of $150.00
Contact Lenses – Covered allowance up to $130.00 and follow up exam
$10.00 Eye Exams at Wallmart & Bainbridge Ophthalmology

Progressive Lenses, Discounts on non-covered items, Specialth Lenses, Pays Out of Network
You must complete a Vision Reimbursement Form for Out-of-Network Claims

See www.dcboebenefits.net for more information

Complete Application

Agent
George E Daniel Jr CIC, CPIA
229-416-7030 Cell / 229-246-3342 Office

Avesis

Advantage Vision

A National Vision and Dental Company

Decatur County Schools - Bainbridge, Georgia

VISION CARE PLAN EMPLOYEE ENROLLMENT FORM

☐ Change ☐ Add ☐ Terminate Effective Date _____

Group Number 30813-08 Plan Number 924 Division All

Employer Group Name Decatur County Board of Education - Bainbridge, Georgia

Date of Employment _____ School Location: _____

Employee Name _____ Date of Birth _____
Last First MI

Address _____ City _____ State _____ Zip _____

Social Security Number _____ ☐ Male ☐ Female

Do you wish to cover your eligible Dependents? ☐ Yes ☐ No

If yes, complete the following: e-mail: _____ Phone: _____

Last I First MI	Date of Birth	Last First MI	Date of Birth
Spouse _____		Child _____	
Child _____		Child _____	
Child _____		Child _____	
Child _____		Child _____	

I hereby **apply** for coverage under Avesis Third Party Administrators, Inc. for which I am now entitled or may become entitled under the provisions of the plan. I authorize deductions from my earnings at the required contributions towards the cost of the coverage. I certify that I am eligible to participate and that the above information is correct. I agree that once enrolled I will remain enrolled during the designated plan period.

☐ I hereby **decline** coverage offered to me by the DCBOE Vision Plan as marked during enrollment. I hereby authorize my employer, until this authorization is revoked by written notice, to deduct each month from any earned wages due me, the amount applicable to the coverage selected.

Date _____ Signature _____

Ed: 062013