



EMPLOYEE APPLICATION and CHANGE FORM

- ★ Comprehensive Medical
- ★ Dental and Vision Direct Reimbursement
- ★ Dental Insurance
- ★ Short Term Disability
- ★ Long Term Disability
- ★ Life Insurance with Accidental Death & Dismemberment
- ★ Dependent Life Insurance

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 named in section 1 of this 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 90-days of continuous employment, check with your Club's Insurance Representative to learn what the Waiting period is. During the Waiting Period you must meet the definition of an Eligible Employee shown above and be Actively at Work and receiving your regular wage or salary from the Club. This Waiting Period will apply to all new employees unless the employee transferred from a 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 is waived. If you have been working at a participating Club on a part-time basis (less than 30 hours per week), those part-time hours may be applied towards meeting the Waiting Period selected by your Club. At least 240 part time hours during the last six months will satisfy the 30 day or the 90 day Waiting Period. Your coverage for any of the plans you are applying for will be effective on the first day of the month following the date that you have satisfied the Waiting Period unless you are a Late Enrollment as described below.

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. You should discuss when your coverage will be effective with the Club's Insurance Representative.

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 deduction. 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. Please refer to the instructions on the back page of this form when you need to change your coverage.

Return This Completed Form to:

(Additional copies can be printed from
www.BGCWA.com)

**BGCWA Insurance Trust
c/o CTI Administrators
100 Court Avenue, Suite 306
Des Moines, IA 50309-2295**

Toll Free Number to CTI Administrators:
1-800-245-8813
Call this number if you have questions about this application or these insurance plans.


Life Insurance and Long Term Disability Insurance are underwritten by UniCare Life & Health Insurance Company

Medical, Dental, Dental with Vision and Short Term Disability Plans are self Insured by the Boys and Girls Club Workers Association Insurance Trust

Original applications are required. Please do not fax.

**Please provide ALL requested information.
An incomplete application will delay the
start of your coverage and must be returned
for completion.**

FOR CTI OFFICE USE ONLY	Case Number		Benefit Code	Effective Date
	Days since Waiting Period	Life Increase <input type="checkbox"/> Yes <input type="checkbox"/> No Over \$100,000 <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Late Enrollee <input type="checkbox"/> Yes <input type="checkbox"/> No	Underwriting Required <input type="checkbox"/> Yes <input type="checkbox"/> No		

1. Club Must Complete	Name of Club		Applicant's Job Title		Annual Salary
	Unit or Department Name		Unit or Dept. No.	If transferring from another Club, please provide Club Name and last day Worked: _____ / ____ / ____	
	Club Address				
	City	State	Zip	If Applicant has worked part time (less than 30 hrs/wk), give total part time hours worked in the 6 months before becoming regular employee: _____	
	Indicate Employee's Job Classification: <input type="checkbox"/> Executive Director/President/CEO <input type="checkbox"/> Assistant Ex Dir <input type="checkbox"/> Program Director <input type="checkbox"/> Director of Operations <input type="checkbox"/> Director of Development <input type="checkbox"/> Director of Finance/Accounting/CFO <input type="checkbox"/> Director of Program Development <input type="checkbox"/> Unit/Branch Mgr <input type="checkbox"/> Area Director <input type="checkbox"/> Office Mgr <input type="checkbox"/> Accounting/Bookkeeper <input type="checkbox"/> Secretary/Receptionist <input type="checkbox"/> Human Resources Mgr <input type="checkbox"/> IT Staff <input type="checkbox"/> Other (please list) _____				
 Signature of Authorized Club Representative			Club Contact Person for Employee Benefits		Club Phone No.

2. Employee Must Complete	Name (Last, First, Middle Initial)		Social Security Number	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
	Address		Date of Birth	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single
	City	State	Zip	Date applicant was employed 30 or more hours per week: _____ / ____ / ____

3. All individuals applying for Medical, Dental or Vision Plans must complete this section.	<u>COMPREHENSIVE MEDICAL INSURANCE</u> - <input type="checkbox"/> Check here if Not Enrolling or Select Medical Plan below: <input type="checkbox"/> Club Select <input type="checkbox"/> Club Choice <input type="checkbox"/> Club Value with Health Reimbursement Account (HRA) Choose who should be covered: <input type="checkbox"/> Myself <input type="checkbox"/> Myself & Spouse <input type="checkbox"/> Myself & Child/Children <input type="checkbox"/> Myself & Family	
	<u>DENTAL INSURANCE or DENTAL WITH VISION DIRECT REIMBURSEMENT PLAN</u> - <input type="checkbox"/> Check here if Not Enrolling, or select type of Plan below: <input type="checkbox"/> Dental and Vision Direct Reimbursement Plan <input type="checkbox"/> Dental Insurance (without Vision) Choose who should be covered: <input type="checkbox"/> Myself <input type="checkbox"/> Myself & Spouse <input type="checkbox"/> Myself & Child/Children <input type="checkbox"/> Myself & Family	

Required information for Dependents to be covered on Medical & Dental Plans.	Relation	Name	Date of Birth	Sex M or F	Check if Married	Currently Enrolled as Full Time Student?	Does Dependent have other Insurance? <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
	Spouse						<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
	Child				<input type="checkbox"/> Married <input type="checkbox"/> Single	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
	Child				<input type="checkbox"/> Married <input type="checkbox"/> Single	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
	Child				<input type="checkbox"/> Married <input type="checkbox"/> Single	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
	Child				<input type="checkbox"/> Married <input type="checkbox"/> Single	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision

Required information for Over Age 18 Full Time Students	<u>Provide Name of Student, Name & Address of School, and Last day of current enrollment</u>
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4. Short Term Disability	<p><u>SHORT TERM DISABILITY INSURANCE –</u> All individuals applying for Short Term Disability must complete this section. <input type="checkbox"/> I am enrolling for Short Term Disability <input type="checkbox"/> I am Not Enrolling for Short Term Disability</p>
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5. Long Term Disability	<p><u>LONG TERM DISABILITY INSURANCE -</u> All individuals applying for Long Term Disability must complete this section. <input type="checkbox"/> I am enrolling for Long Term Disability <input type="checkbox"/> I am Not Enrolling for Long Term Disability</p>
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6. Life Insurance for Employees and Dependent Life Insurance All individuals applying for Life Insurance coverage must complete this section.	<p><u>TERM LIFE INSURANCE (with Accidental Death & Dismemberment)</u> - Specify the amount of coverage you desire. I request Life Insurance in the following amount (limit is 3 times salary not to exceed \$400,000) <input type="checkbox"/> \$10,000 or <input type="checkbox"/> \$ _____ lump sum amount if over \$10,000 (in \$1,000 increments) <input type="checkbox"/> 1 times annual salary <input type="checkbox"/> 2 times annual salary <input type="checkbox"/> 3 times annual salary <input type="checkbox"/> None</p> <p><u>SPOUSE LIFE INSURANCE</u> Indicate amount of coverage desired (in \$1,000 increments up to \$75,000 -- Not to exceed amount of employee’s coverage): I also request spouse coverage in the following amount \$ _____...(amounts over \$20,000 require spouse to complete the “Personal Health Statement of Dependent” which is available from CTI Administrators or from www.BGCWA.com)</p> <p><u>CHILDREN’S LIFE INSURANCE</u> –(each child is covered for \$10,000) Check if children’s coverage is desired. I also request children’s life insurance <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>ADDITIONAL LIFE INSURANCE or COVERAGE AMOUNTS OVER \$100,000 If you are requesting additional Life Insurance or amounts of coverage greater than \$100,000, you will be required to complete a Personal Health Statement that will require approval by UniCare before coverage is granted. The Personal Health Statement can be obtained from CTI Administrators or from www.BGCWA.com</p> <p>LATE ENROLLEES 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 Personal Health Statement that will require approval by UniCare before coverage is granted. The Personal Health Statement can be obtained from CTI Administrators or from www.BGCWA.com</p> <p><u>BENEFICIARY DESIGNATION</u> <i>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.</i></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50%;">Beneficiary Name(s)</th> <th style="width: 20%;">Relationship</th> <th style="width: 30%;">Percent of Benefit</th> </tr> </thead> <tbody> <tr> <td style="height: 40px;"></td> <td></td> <td></td> </tr> </tbody> </table>	Beneficiary Name(s)	Relationship	Percent of Benefit			
Beneficiary Name(s)	Relationship	Percent of Benefit					

7. Please read this Agreement then sign & date where indicated.	<p><u>Agreement</u></p> <p>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 and UniCare Life & Health Insurance Company if applying for 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.</p> <p>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.</p> <p>I understand that as a Late Enrollment, Medical benefits may be delayed and may not be payable for a Pre-existing condition and that Long Term and Short Term Disability benefits will not be paid for my first 12 months of coverage for a Pre-existing condition.</p> <p>I understand that if I have not applied for insurance for which I am now eligible, satisfactory evidence of insurability may be required should I desire to apply at a later date; and any such application may be declined on the basis of such evidence.</p> <p>I authorize my employer to deduct from my earnings any required contribution for the insurance to which I am, or may become entitled.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;"> Signature of Applicant</td> <td style="width: 30%; text-align: right;">Date</td> </tr> <tr> <td style="border-top: 1px solid black; border-bottom: 1px solid black;"></td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; text-align: right;">____/____/____</td> </tr> </table>	Signature of Applicant	Date		____/____/____
Signature of Applicant	Date				
	____/____/____				

Change Request Form

Please use this form to request a change to your current coverage

Type of Change	Supporting Information	Reason for Change
Name Change	Complete section 2 of the application using your new name. Print former name below:	
Change Medical Plan to: <input type="checkbox"/> Club Select <input type="checkbox"/> Club Choice or <input type="checkbox"/> Club Value w/HRA	Complete section 1, 2, 3, and 7 of the application.	
Change Medical Coverage to: <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Children <input type="checkbox"/> Entire Family <input type="checkbox"/> Retiree Only <input type="checkbox"/> Retiree & Spouse <input type="checkbox"/> Limited Hours Employee <input type="checkbox"/> Discontinue Medical	Complete section 1, 2, 3, and 7 of the application.	<input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Marriage/Divorce <input type="checkbox"/> Death <input type="checkbox"/> Loss of Insurance <input type="checkbox"/> Dependent no longer eligible <input type="checkbox"/> Other _____ Date of event checked above ___/___/___
Change Dental or Dental /Vision Coverage to: <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Children <input type="checkbox"/> Entire Family <input type="checkbox"/> Retiree Only <input type="checkbox"/> Retiree & Spouse <input type="checkbox"/> Limited Hours Employee <input type="checkbox"/> Discontinue Dental	Complete section 1, 2, 3, and 7 of the application.	<input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Marriage/Divorce <input type="checkbox"/> Death <input type="checkbox"/> Loss of Insurance <input type="checkbox"/> Dependent no longer eligible <input type="checkbox"/> Other _____ Date of event checked above ___/___/___
Adding or Discontinuing Short Term Disability: <input type="checkbox"/> Add STD Coverage <input type="checkbox"/> Discontinue STD	Complete section 1, 2, 4, and 7 of the application if adding coverage.	
Adding or Discontinuing Long Term Disability: <input type="checkbox"/> Add LTD Coverage <input type="checkbox"/> Discontinue LTD	Complete section 1, 2, 5, and 7 of the application if adding coverage.	
Adding or Changing Amount of Life Insurance	Complete section 1, 2, 6, and 7 of the application.	
Changing Life Insurance Beneficiary Designation	Complete section 1, 2, 6, and 7 of the application.	
*If requesting additional Life Insurance , please indicate requested amount in Section 6, and complete a Personal Health Statement. Personal Health Statements can be downloaded at www.BGCWA.com under on-line forms.		

Signature of Applicant _____	Date ___/___/___
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Remember to have your Authorized Club Representative complete and sign section 1.

For Questions Call CTI Administrators (800) 245-8813