



Council Accident & Sickness Insurance Plan Annual Enrollment Form

Councils can choose either one of two plans, two optional benefits and two premium payment methods. Plan 1 insures Youth members only (including unpaid seasonal staff). Plan 2 insures Youth & Adults. The council can also elect to insure their Learning for Life Curriculum-based participants and/or Family Member Coverage. Please complete all information requested. Allow 15 days for mailing and processing. Coverage does not become effective until Health Special Risk Inc., receives the Enrollment Form and premium unless a later date is specified.

Council Name: _____ Council Number: _____

Council Address: _____

City, State & Zip: _____ Telephone: _____

Scout Executive: _____ Email Address: _____

Plan desired:

- Plan 1: Youth Only. Enter the average number of Youths registered for the previous 12 months.
Plan 2: Youth & Adults. Enter the average number of Youths & Leaders (include Den aides/chiefs) registered for the previous 12 months.

For both Plan 1 and Plan 2, all Lion Cubs and Tiger Cubs must have a Lion or Tiger Parent registered.

Table with 4 columns: Group, Youth Plan 1, Youth Plan 2, Adults Plan 2. Rows include Lion Cubs, Tiger Cubs & Lion and Tiger Cub Adult Partners, Cubs, Scouts, Venturers, Sea Scouts, Seasonal Staff/Others, Learning for Life Explorers, Total Participants, and Subtotal Premium.

Optional Coverage

Learning for Life Curriculum-based Participant Coverage:

Table with 4 columns: LFL curriculum-based participants, Youth Plan1, Youth Plan2, Adult Plan 2. Rows include LFL curriculum-based participants and Subtotal Premium.

Family Member Coverage: for Parents, Grandparents & Siblings attending BSA Council Sponsored Family Events. The premium cost is \$0.05 per person per day.

Table with 4 columns: Estimated # of family members expected to attend Family Events in 2024, Average Length (days) of each Family Event, Subtotal Premium (Multiple the est. # X the average days X \$0.05), Youth Plan1, Youth Plan2, Adult Plan 2.

Grand Total: Annual Premium for all coverages: \$ _____

Premium Payment (select one): [] Annual: Submit the full amount above now. [] Semiannual: Submit 1/2 the amount above, you will be billed for the balance.

Amount Enclosed: \$ _____ Desired Effective Date: _____

Attach a check & mail to Health Special Risk, Inc. PO Box 957946, St. Louis, MO 63195-7946. For assistance, please call toll-free 1-866-726-8870.