BOY SCOUTS OF AMERICA®

HSR Health Special Risk, Inc.

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 Tiger Cubs must have a Tiger Cub Parent registered.

Group	Youth Plan 1	Youth Plan 2	Adults Plan 2
Tiger Cubs& Tiger Cub Adult Partners			
Cubs			
Scouts			
Varsity Scouts			
Venturers			
Unpaid Seasonal Staff/Others			
Learning for Life Explorers			
Total Participants:			
	X .82 / person	X .82 / person	X .82 / person
Subtotal Premium:			

Optional Coverage

Learning for Life Curriculum–based Participant Coverage:

	Youth Plan1	Youth Plan2	Adult Plan 2
LFL curriculum-based participants			
	X .67 / person	X .67 / person	X .67 / person
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.

	Youth Plan1	Youth Plan2	Adult Plan 2
Estimated # of family members expected to attend Family Events in 2015			
Average Length (days) of each Family Event			
	X .05/person/day	X .05/person/day	X .05/person/day
Subtotal Premium (Multiple the est. # X the average days X $0.05)			

Grand Total: Annual Premium for all coverages: $ _____

Premium Payment (select one): ☐ **Annual:** Submit the full amount above now.

☐ **Semiannual:** Submit ½ 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 674072, Dallas, TX 75267-4072. For assistance, please call toll-free 1-866-726-8870.