BEST HEALTH PLAN
Boards of Education Self-Funded Trust

ENROLLMENT / CHANGE FORM

CREEDE SCHOOL DISTRICT (CREEDE)

apostrophe
855-999-2107 | hi@apostrophehealth.com

Select reason(s) for enrollment / change and indicate effective date: ***must be submitted within 31 days of event***

☐ New Coverage ☐ Change Coverage ☐ Change Name/Address ☐ Add Spouse/Dependents ☐ Drop Spouse/Dependents	REASON FOR CHANGE	EFFECTIVE DATE

EMPLOYEE INFORMATION — *complete all fields*

LAST NAME		LEGAL FIRST NAME		MIDDLE NAME (or initial)
GENDER	DATE OF BIRTH	SSN		NICKNAME
HOME PHONE	MOBILE PHONE	EMAIL ADDRESS		
ADDRESS		CITY	STATE	ZIPCODE
MARITAL STATUS ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Separated ☐ Single ☐ Common Law ☐ Widow ☐ Widower		JOB TITLE		HIRE DATE

MEDICAL PLAN		*COVERAGE LEVEL*
		☐ Employee Only ☐ Employee + Child(ren) ☐ Employee + Spouse ☐ Employee + Family
WAIVE COVERAGE ***must be completed if coverage is waived for yourself and/or any dependents***	☐ Self	☐ Spouse's Coverage ☐ Medicare ☐ Medicaid ☐ Other (explain):
	☐ Spouse	☐ Spouse's Coverage ☐ Medicare ☐ Medicaid ☐ Other (explain):
	☐ Children	☐ Spouse's Coverage ☐ Medicare ☐ Medicaid ☐ Other (explain):

I acknowledge that the available coverage has been explained to me by my employer, and I know that I have every right to apply for coverage. I have the chance to apply for this coverage and I have decided not to enroll myself and/or dependent(s). I understand that evidence of insurability may be required should I choose to apply for coverage at a later date under special enrollment rights. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to decline coverage.

DEPENDENT(s) COVERED ON THE PLAN — *complete all fields*

SPOUSE

LAST NAME	FIRST NAME	SSN	DOB (MM-DD-YYYY)	GENDER

EMAIL	HOME PHONE	MOBILE PHONE	OTHER INSURANCE (Employer name, Name of carrier, Effective date)

CHILD/DEPENDENT

LAST NAME	FIRST NAME	SSN	DOB (MM-DD-YYYY)	GENDER	OTHER INSURANCE (Employer name, Name of carrier, Effective date)

CHILD/DEPENDENT

LAST NAME	FIRST NAME	SSN	DOB (MM-DD-YYYY)	GENDER	OTHER INSURANCE (Employer name, Name of carrier, Effective date)

CHILD/DEPENDENT

LAST NAME	FIRST NAME	SSN	DOB (MM-DD-YYYY)	GENDER	OTHER INSURANCE (Employer name, Name of carrier, Effective date)

CHILD/DEPENDENT

LAST NAME	FIRST NAME	SSN	DOB (MM-DD-YYYY)	GENDER	OTHER INSURANCE (Employer name, Name of carrier, Effective date)

If any listed dependents have different last name than employee, explain and attach documentation (marriage certificate/common law paperwork, etc). Plan allows all dependents up to age 26 to participate in the health plan. Attach additional documentation if more than 4 child/dependents.

By signing below, I acknowledge that my selections are complete and the information provided on this form is true and correct to the best of my knowledge. I understand that my benefits may be affected by failure to provide complete, accurate and timely information. I understand that in order to be covered under BEST Health Plan or my employer's medical plan, enrollment must be received in Human Resources within 31 days of the qualifying event, i.e., date of hire, employment status change, family status change, etc. I understand that if I, at some future date, desire to become insured for any of the coverage waived, I must comply with all late enrollee penalties or provisions of special enrollment.

I request coverage for myself and any eligible dependents as listed on this form and authorize my employer to make required payroll deductions, if any, as my contribution for the premium. I agree to be bound by all terms of the applicable benefit plan documents under which I am applying for coverage. All medical information is strictly confidential; however, I authorize release of medical information necessary to perform internal administrative functions. I also authorize disclosure of medical information to my employer for purposes of utilization review or financial audit. This authorization shall become effective immediately and shall remain in effect for as long as I have coverage under the plan and as is necessary to enable Apostrophe to process claims. I agree that a copy of this authorization shall be as valid as the original.

EMPLOYEE'S SIGNATURE ______________________ DATE SIGNED ______________________