BEST HEALTH PLAN
Boards of Education Self-Funded Trust

uchealth

GROUP: MORGAN COUNTY SCHOOL DISTRICT ENROLLMENT / CHANGE FORM

Please print clearly, using blue or black ink.

DATE OF HIRE: __ __ /__ __ / __ __ | **EFFECTIVE DATE: __ __ / __ __ / __ __** | ☐ **CHANGE NAME / ADDRESS**

EMPLOYEE INFORMATION

Social Security Number	Legal Last Name	Legal First Name	M.I.	Email Address

Mailing Address	Home Phone	Mobile Phone	Date of Birth

Apt/Unit #	City	State	Zip	Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated

BENEFIT CHOICES

Before completing this section, please review the benefit details and required payroll deductions for each choice.

☐ **WAIVE MEDICAL COVERAGE** ☐ **WAIVE DENTAL COVERAGE** ☐ **WAIVE VISION COVERAGE**

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.

MEDICAL ELECTION	DENTAL ELECTION	VISION ELECTION
☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Family	☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Family	☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Family
MEDICAL PLAN TYPE: ☐ Cost-sharing Plan ☐ HDHP + HSA Compatible ☐ HDHP + Extra Benefits		

ENROLLMENT INFORMATION

Please provide the requested information for yourself and all dependents who will be covered by any of the benefits chosen above. If any listed dependents have a different last name than the employee, explain and attach supporting documentation; e.g., marriage certificate, common law paperwork, etc.

Dependents up to age 26 are eligible to participate in the health plan. Attach an additional enrollment form if you are enrolling more than 4 child dependents.

Note: SOCIAL SECURITY NUMBERS are REQUIRED on all members for Federal reporting purposes only.

Member	Last Name	First Name	Sex	Change	Date of Birth (mm/dd/yy)	Social Security Number
Employee			☐ M ☐ F	☐ Add ☐ Drop		
Spouse			☐ M ☐ F	☐ Add ☐ Drop		
Child			☐ M ☐ F	☐ Add ☐ Drop		
Child			☐ M ☐ F	☐ Add ☐ Drop		
Child			☐ M ☐ F	☐ Add ☐ Drop		
Child			☐ M ☐ F	☐ Add ☐ Drop		

Do you or any of your dependents currently have other coverage, including Medicare? ☐ No ☐ Yes; please provide the following information:

Member Name	Employer Name	Insurance Company Name	Policy Number	Medicare A, B or both

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, 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 certify that, to the best of my knowledge, the information shown on this form is correct. My signature below will serve as permission for release of personal medical information or records from any current or previous healthcare provider or facility to BEST Health Plan and UCHealth Plan Administrators for the use of my healthcare plan and wellness program administration. I agree that a copy of this authorization shall be as valid as the original.

Employee Signature: **Date:**