ENROLLMENT/CHANGE FORM

(Changes must be submitted within 31 days of event)

GROUP NAME: SARGENT SCHOOL DISTRICT

GROUP NUMBER: 70009SF-11

Phone: 719.589.3696
1.800.475.8466
Fax: 303.302.2711

EFFECTIVE DATE OF ENROLLMENT/CHANGE: _____ / _____ /_____

CHECK ALL APPLICABLE BOXES

☐ NEW ENROLLMENT	☐ COVERAGE/STATUS CHANGE	☐ NAME CHANGE
☐ ADD SPOUSE/DEPENDENT(S)	☐ DROP SPOUSE/DEPENDENT(S)	☐ ADDRESS CHANGE

SELECT MEDICAL COVERAGE

MEDICAL PPO	☐ EMPLOYEE ONLY (EE)	☐ EMPLOYEE + FAMILY

WAIVE MEDICAL COVERAGE (MUST BE COMPLETED IF ANY COVERAGE IS WAIVED FOR MYSELF AND/OR DEPENDENTS)

☐ MYSELF	☐ COVERED BY SPOUSE'S GROUP COVERAGE	☐ MEDICARE	☐ OTHER: _____
☐ SPOUSE	☐ COVERED BY SPOUSE'S GROUP COVERAGE	☐ MEDICARE	☐ OTHER: _____
☐ CHILDREN	☐ COVERED BY SPOUSE'S GROUP COVERAGE	☐ MEDICARE	☐ OTHER: _____

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.

EMPLOYEE INFORMATION (COMPLETE ALL FIELDS BELOW)

LAST NAME OF EMPLOYEE		**MIDDLE INITIAL**	**FIRST NAME**
GENDER	**HOME PHONE/CELL PHONE**	**DATE OF BIRTH**	**EMAIL**
ADDRESS		**CITY**	**STATE** / **ZIP**
SSN # OF EMPLOYEE		**MARITAL STATUS**	**DATE OF EMPLOYMENT**

COMPLETE ALL INFORMATION FOR DEPENDENTS TO BE COVERED

DEPENDENT	LAST NAME	FIRST NAME	SSN#	DOB	GENDER	OTHER INSURANCE COVERAGE INCLUDING MEDICARE (Employer name, Name of carrier, Effective date) If no other coverage, state NONE
SPOUSE						
CHILD/DEP.						
CHILD/DEP.						
CHILD/DEP.						
CHILD/DEP.						

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.

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 Colorado Choice to process claims. I agree that a copy of this authorization shall be as valid as the original.

_____ _____ / _____ / _____

EMPLOYEE'S SIGNATURE DATE SIGNED