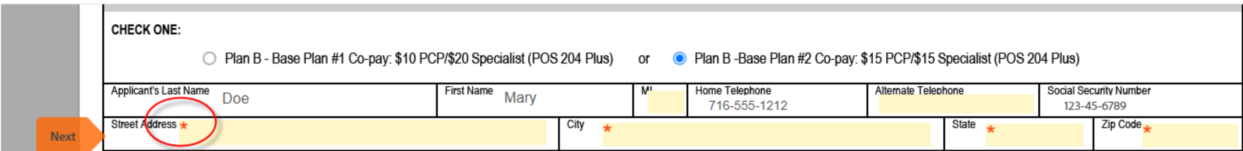
Instructions on how to fill out an

Adobe Sign Form

All text boxes that are of the yellowish color can be filled out electronically – please just start typing the correct information. If you see a RED ASTERICK, it is a required field and the document will not move to the signature page if it is not completed.



CHECK ONE:

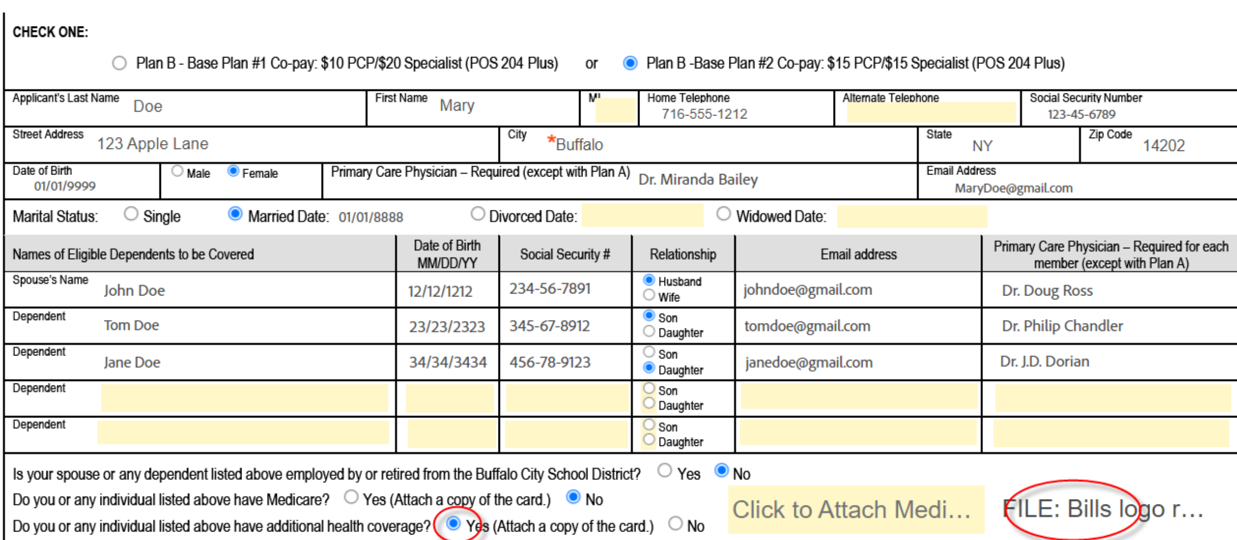
Plan B - Base Plan #1 Co-pay: $10 PCP/$20 Specialist (POS 204 Plus) or Plan B -Base Plan #2 Co-pay: $15 PCP/$15 Specialist (POS 204 Plus)

Applicant's Last Name	First Name	MI	Home Telephone	Alternate Telephone	Social Security Number
Doe	Mary		716-555-1212		123-45-6789

Street Address *	City *	State *	Zip Code *

Next

There are text boxes that allow you to attach required documents. When you click on the text box, it will open a browser window that allows you to select the required PDF, PNG or JPG file.



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Plan B - Base Plan #1 Co-pay: $10 PCP/$20 Specialist (POS 204 Plus) or Plan B -Base Plan #2 Co-pay: $15 PCP/$15 Specialist (POS 204 Plus)

Applicant's Last Name	First Name	MI	Home Telephone	Alternate Telephone	Social Security Number
Doe	Mary		716-555-1212		123-45-6789

Street Address	City	State	Zip Code
123 Apple Lane	*Buffalo	NY	14202

Date of Birth	Male / Female	Primary Care Physician – Required (except with Plan A)	Email Address
01/01/9999	Female	Dr. Miranda Bailey	MaryDoe@gmail.com

Marital Status: Single Married Date: 01/01/8888 Divorced Date: Widowed Date:

Names of Eligible Dependents to be Covered	Date of Birth MM/DD/YY	Social Security #	Relationship	Email address	Primary Care Physician – Required for each member (except with Plan A)
Spouse's Name John Doe	12/12/1212	234-56-7891	Husband / Wife	johndoe@gmail.com	Dr. Doug Ross
Dependent Tom Doe	23/23/2323	345-67-8912	Son / Daughter	tomdoe@gmail.com	Dr. Philip Chandler
Dependent Jane Doe	34/34/3434	456-78-9123	Son / Daughter	janedoe@gmail.com	Dr. J.D. Dorian
Dependent			Son / Daughter		
Dependent			Son / Daughter		

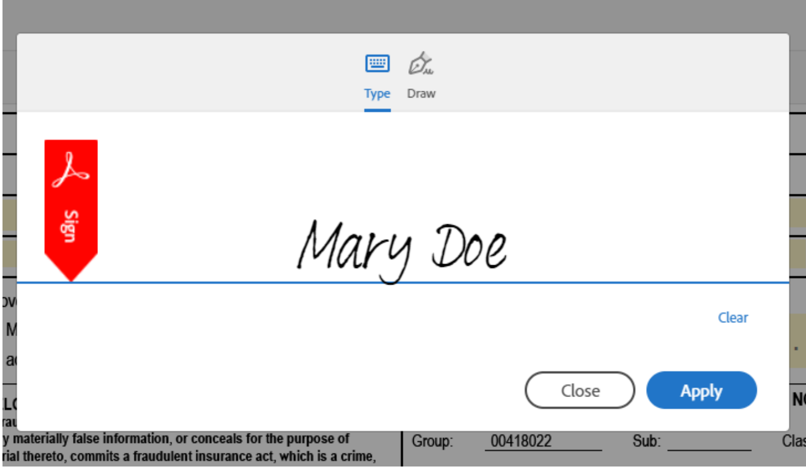
Is your spouse or any dependent listed above employed by or retired from the Buffalo City School District? Yes No

Do you or any individual listed above have Medicare? Yes (Attach a copy of the card.) No

Do you or any individual listed above have additional health coverage? Yes (Attach a copy of the card.) No

Click to Attach Medi… FILE: Bills logo r…

Once your information is entered, please add your signature by clicking on the Signature text box, and they type or draw your name and click apply.



Continue to enter information in all appropriate and required fields, and upload dependent eligibility verification, as appropriate.

HEALTH INSURANCE NEW ENROLLMENT ATTESTATION

PART II: CHECK ONE OF THE FOLLOWING

○ I am applying for Single Coverage.

◉ I am applying for Family Coverage and have enclosed the appropriate documentation.

Coverage for Spouse requires:

- Copy of Marriage Certificate

Coverage for Dependent Child(ren) requires one of the following:

- Copy of Birth Certificate (naming you or your spouse as parent)
- Copy of Adoption Decree (naming you or your spouse as adoptive parent)
- Copy of Court Granted Guardianship (naming you or your spouse as legal guardian)

PART III: ACKNOWLEDGEMENT

I affirm that the information in my health insurance application is true. I understand that the information given to the Benefits Department, including contact information such as address and telephone number, must be accurate and kept accurate at all times. All changes must be reported to the Benefits Department **within 30 days**.

I understand if I qualify to add a dependent to my insurance in the future I must complete the appropriate application and provide the required verifications **within 30 days** of the event. **If I do not report additions to my insurance in a timely manner, I understand that I must wait until the next Open-Enrollment period.**

I also understand and agree to remove dependents within 30 days of the event which makes them ineligible for my insurance, including divorce, death and the aging off of a dependent child. I have read the eligibility guidelines provided in this packet

Mary Doe
Signature

09/14/2022
Date

Mary Doe
Print Name

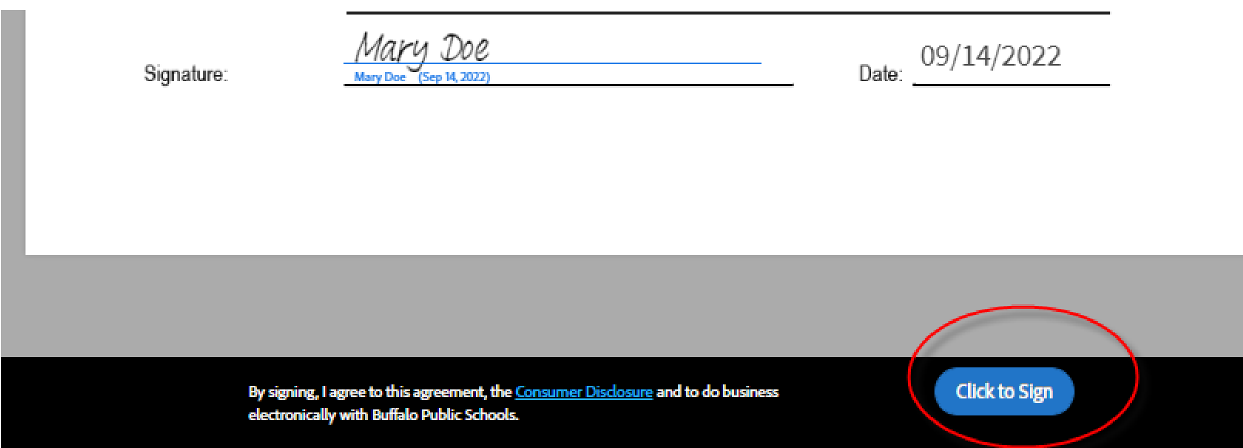
123-45-6789
Employee # or Social Security Number

FILE: Bills logo red and blue.jpg
FILE: Bills logo.png
FILE: Bills One Buffalo.jpg
Click to Attach Birth Certificate 4
Click to Attach Birth Certificate 5

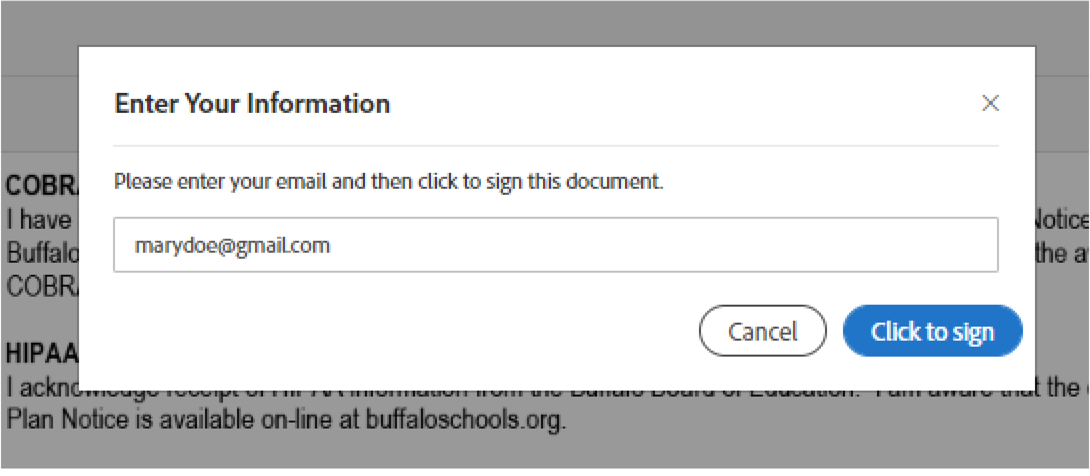
MUST ACCOMPANY PAGE 1 OF THE HEALTH INSURANCE ENROLLMENT FORM

When you have selected choices/entered text into all of the required fields, a black pop-up banner appears along the bottom of your screen and gives you the abilityt to

"click to sign". This is the process to collecy your electronic signature and must be completed before the system gives you the prompt to submit.



Add the email address you want the completed document to be sent to, and click sign.



The system will automatically generate a screen* telling you EITHER

YOU'RE ALL SET – Your enrollment form has been emailed to the additional signer (the Benefits Office) for signature

OR

JUST ONE MORE STEP – You will receive an email to confirm your email address before the form is submitted to the additional signer (the Benefits Office) for signature.

***Please note – during times of high volume, such as the start of the school year or open enrollment, it may take the system longer to generate the screen, up to a half hour.**

Thank you for signing BEST HI Enrollment
It has now been emailed to the additional signer(s) for their signature. A signed copy will be sent to you after all the signers have signed the agreement. You can also download a copy of what you just signed.

Please allow the Benefits Office 2 – 3 business days to process your enrollment form. Once done, you will receive a confirmation along with the final agreement to your email account. If you have not received one within that timeframe, please check your Spam or Junk folders.