of Tennessee

1 Cameron Hill Circle
Chattanooga, TN 37402-0001
bcbst.com
- CONFIDENTIAL -

EMPLOYEE ENROLLMENT / WAIVER

PLEASE USE BLUE OR BLACK INK ONLY
IF YOU ARE DECLINING COVERAGE, PLEASE GO TO BACK OF FORM.

Plan Use Only
Rec:_____

EEW-15

Section 1 – Group / Employer Information – This form cannot be processed without this information

GROUP NO. | SUBGROUP NO. | DEPARTMENT NO. | GROUP NAME

COVERAGE EFFECTIVE DATE: Medical __/__/____ Dental __/__/____ Vision __/__/____ FSA __/__/____

NEW ENROLLMENT (CHECK IF APPLICABLE):
- ❑ New Hire ❑ Open Enrollment ❑ Rehire
- ❑ Part-time change to Full-time

Full-time Date of Hire: __/__/____ Hrs Wkd/Wk ____
Part-time / Rehire Date: __/__/____

QUALIFYING EVENT:
- ❑ Loss of Other Medical Cvg ❑ Loss of Other Dental Cvg
- ❑ Loss of Other Vision Cvg ❑ Marriage ❑ New Dental Child
- ❑ Court Order ❑ Other (FSA Only) ❑ Continuation Coverage Period Expired

EVENT DATE: __/__/____

❑ COBRA OR ❑ STATE CONTINUATION:
- ❑ Termination of Employment (Voluntary or Involuntary) ❑ Employee Eligible for Medicare
- ❑ Reduction in Hours ❑ Dependent Child No Longer Eligible
- ❑ Divorce/Legal Separation ❑ Death of Employee

EVENT DATE: __/__/____

Section 2 - Employee/Member Information – Employee Must Complete In Full

ELECT: Medical Option: ❑ 1 ❑ 2 ❑ 3 ❑ 4 Other _____ ❑ Ind ❑ Fam ❑ EE/Spouse ❑ EE/Child(ren)

ELECT: Dental Option: ❑ 1 ❑ 2 ❑ 3 ❑ 4 Other _____ ❑ Ind ❑ Fam ❑ EE/Spouse ❑ EE/Child(ren)

ELECT: Vision Option: ❑ 1 ❑ 2 ❑ 3 ❑ 4 Other _____ ❑ Ind ❑ Fam ❑ EE/Spouse ❑ EE/Child(ren)

ELECT: FSA: ❑ Health Care: $ _____.__ Annual Pledge Amount*

❑ Dependent Care: $ _____.__ Annual Pledge Amount*

If your Group does not offer a debit card with FSA, should BCBST automatically pay Health Care FSA funds when medical claims are processed? ❑ **YES** ❑ **NO**

OTHER INSURANCE
If you or listed dependents will be covered by other medical/Medicare or dental insurance when this plan goes into effect, indicate which coverage.
❑ Medical/Medicare ❑ Dental

HICN _____

EMPLOYEE LAST NAME | EMPLOYEE FIRST NAME | MI | JR., SR., ETC. | SSN/TIN** | DATE OF BIRTH __/__/19__ | ❑ Male ❑ Female

ADDRESS

❑ **SPANISH IS MY PRIMARY HOUSEHOLD LANGUAGE**

CITY (Please do not abbreviate) | STATE | ZIP | EMAIL ADDRESS***

PAID CLASSIFICATION
❑ Hourly ❑ Salary ❑ Retiree ❑ Surviving Spouse

JOB CLASSIFICATION
❑ Management ❑ Non-Management ❑ Exec/Officer/Owner

JOB TITLE | PAYROLL NO.

Section 3 – Acknowledgement - Signature and Date MUST BE COMPLETED

Employee should notify BlueCross BlueShield of Tennessee if any dependent's address is different from the employee's address. It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of coverage. I understand, and agree, that I am applying for coverage and: 1) that any contract which may be issued to me will be subject to all the terms and conditions of the Group Agreement; 2) that my signature on this form will authorize any doctor, hospital, or other provider of treatment to furnish BlueCross BlueShield of Tennessee any and all medical records pertaining to any person covered by the contract; 3) that I am responsible for any fee for these records; and 4) that Health and Dependent Care Flexible Spending Accounts (FSAs) are on a pre-tax basis and they cannot be changed prior to the end of the plan year unless a change in status event occurs as defined in the Summary Plan Description and I will forfeit any amount remaining in the account after all eligible expenses are submitted for reimbursement should I over estimate my annual needs.

Employee's Signature: X _____ Date: __/__/____ Phone: ___-___-____

*Annual maximum applies. See your Benefits Administrator if you have questions. **To comply with Federal regulations we must have SSN/TIN. ***By providing your email address, you are agreeing to receive all communications (presently available or that become available during the term of your policy) related to this policy, the benefits considered under this policy, your relationship with BCBST, etc., in electronic form from BCBST or its subsidiaries.*

A scanned, imaged or photocopied version of this completely executed form will have the same force and effect as the original document.

GROUP NO. | EMPLOYEE LAST NAME | EMPLOYEE FIRST NAME

EEW-15

Section 4 - Dependent Information - Please provide all information for each person to be covered. Consult employer guidelines for dependent eligibility.

SPOUSE LAST NAME | SPOUSE FIRST NAME | MI | JR., SR., ETC. | DATE OF BIRTH | Male ❑ Female ❑ | SSN/TIN**

(1) DEPENDENT LAST NAME | DEPENDENT FIRST NAME | MI | JR., SR., ETC. | DATE OF BIRTH | Male ❑ Female ❑ | SSN/TIN**

❑ Natural Child/Stepchild ❑ Adopted/Legal Guardian ❑ Other (specify) ❑ Physically Handicapped ❑ Full-time Student Over 19

(2) DEPENDENT LAST NAME | DEPENDENT FIRST NAME | MI | JR., SR., ETC. | DATE OF BIRTH | Male ❑ Female ❑ | SSN/TIN**

❑ Natural Child/Stepchild ❑ Adopted/Legal Guardian ❑ Other (specify) ❑ Physically Handicapped ❑ Full-time Student Over 19

(3) DEPENDENT LAST NAME | DEPENDENT FIRST NAME | MI | JR., SR., ETC. | DATE OF BIRTH | Male ❑ Female ❑ | SSN/TIN**

❑ Natural Child/Stepchild ❑ Adopted/Legal Guardian ❑ Other (specify) ❑ Physically Handicapped ❑ Full-time Student Over 19

Section 5 – Ancillary Insurance Information ***(NOTE: Products are offered by USAble Life or other carriers which are independent and solely responsible. These are NOT BlueCross BlueShield products.)***

ELECT (Mark all that apply): ❑ Basic Life/ADD ❑ Dependent Life ❑ STD ❑ LTD ❑ Supplemental Life/ADD Life Class Annual Salary $ .00

BASIC LIFE INSURANCE AMT $ .00 OR TIMES SALARY

SUPPLEMENTAL LIFE/ADD AMT $ .00 OR TIMES SALARY

BENEFICIARY	RELATIONSHIP	PERCENTAGE	BENEFICIARY	RELATIONSHIP	PERCENTAGE
1			3		
2			4		

Section 6 – Waiver of Coverage - Complete this section to waive coverage, however, your Employer may require an additional, separate waiver form.

DECLINE COVERAGE – I understand that I have been offered, and have declined, coverage sponsored by my employer.

Medical ❑ Dental ❑ Vision ❑ Basic Life/ADD ❑ Dependent Life ❑ STD ❑ LTD ❑ Supplemental Life/ADD ❑

Reason for declining (Mark all that apply):

❑ Other group medical coverage ❑ Other group dental coverage
❑ Other group vision coverage ❑ I have TennCare
❑ Other

GROUP NO. | GROUP NAME

EMPLOYEE LAST NAME | EMPLOYEE FIRST NAME | EMPLOYEE DATE OF BIRTH

WAIVER SIGNATURE (Note: Signature also required in Section 3 when electing any coverage) X

DATE

Special Enrollment Period for Medical, Dental and Vision: An Employee or eligible dependent who did not apply for coverage within thirty-one (31) days of first becoming eligible for coverage under this Plan may enroll if: 1) he or she had other health care coverage at the time coverage under this plan was previously offered; and 2) he or she stated, in writing, at the time coverage under this Plan was previously offered, that such other coverage was the reason for declining coverage under this Plan; and 3) such other coverage is exhausted (if the other coverage was continuation coverage under COBRA) or the other coverage was terminated because he or she ceased to be eligible due to involuntary termination or employer contributions for such coverage ended; and 4) he or she applies for coverage under this Plan and the administrator receives the change form within thirty-one (31) days after the loss of other coverage. The Employee also may enroll at the next Open Enrollment Period.