RESET

STATE OF TENNESSEE GROUP INSURANCE PROGRAM

# ENROLLMENT CHANGE APPLICATION

Knox County Schools • Benefits and Employee Relations Department
Post Office Box 2188 • Knoxville, TN 37901-2188 • Fax (865) 594-9523

PARTNERS FOR HEALTH

## PART 1: ACTION REQUESTED — PLEASE SEE PAGE 4 FOR INSTRUCTIONS

**TYPE OF ACTION**
- ☑ Add coverage
- ☐ Change coverage
- *Form not for cancellation

**COVERAGE AFFECTED**
- ☑ Health

**PARTICIPANTS AFFECTED**
- ☐ Employee
- ☐ Spouse
- ☐ Child(ren)

**REASON FOR THIS ACTION**
- ☐ New Hire/Newly Eligible
- ☐ Termination
- ☐ Court Order
- ☐ Other _____

Life Event
- ☐ Marriage
- ☐ Newborn
- ☐ Legal Guardianship
- ☐ Adoption

Special Enrollment (also complete pg 3)
- ☐ Death
- ☐ Divorce
- ☐ Loss of Eligibility

## PART 2: EMPLOYEE INFORMATION

| FIRST NAME | MI | LAST NAME | DATE OF BIRTH | GENDER | MARITAL STATUS |
|---|---|---|---|---|---|
| | | | | ☐ M ☐ F | ☐ S ☐ M ☐ D ☐ W |

| SOCIAL SECURITY NUMBER | EMPLOYING AGENCY | EMPLOYER GROUP | YOUR CURRENT STATUS |
|---|---|---|---|
| | Knox County Schools | ☐ UT ☐ TBR ☐ State ☑ Local Ed ☐ Local Gov | ☑ Active ☐ COBRA |

| HOME ADDRESS | ☐ UPDATE MY ADDRESS | CITY | ST | ZIP CODE | COUNTY |
|---|---|---|---|---|---|
| | | | | | |

## PART 3: HEALTH COVERAGE SELECTION

**SELECT AN OPTION**
- ☐ Premier PPO
- ☐ Standard PPO

**LOCAL ED & GOV ONLY MAY ALSO CHOOSE**
- ☐ Limited PPO
- ☐ Local HealthSavings CDHP

**SELECT A CARRIER**
- ☐ BlueCross BlueShield Network S
- ☐ Cigna LocalPlus
- ☐ Cigna Open Access (surcharge applies)

**REGION WHERE YOU LIVE OR WORK**
- ☑ East
- ☐ Middle
- ☐ West

**SELECT A HEALTH PREMIUM LEVEL**
- ☐ employee only
- ☐ employee + child(ren)
- ☐ employee + spouse
- ☐ employee + spouse + child(ren)

## PART 4: DEPENDENT INFORMATION — ATTACH A SEPARATE SHEET IF NECESSARY

| NAME (FIRST, MI, LAST) | DATE OF BIRTH | RELATIONSHIP | GENDER | ACQUIRE DATE * | SOCIAL SECURITY NUMBER | HEALTH |
|---|---|---|---|---|---|---|
| | | | ☐ M ☐ F | | | ☐ |
| | | | ☐ M ☑ F | | | ☐ |
| | | | ☑ M ☐ F | | | ☐ |
| | | | ☐ M ☐ F | | | ☐ |
| | | | ☐ M ☐ F | | | ☐ |
| | | | ☐ M ☐ F | | | ☐ |

* The acquire date is the date of marriage, birth, adoption or guardianship.
Proof of a dependent's eligibility must be submitted with this application for all new dependents (see page 2).

☐ A separate sheet with more dependents is attached

## PART 5: EMPLOYEE AUTHORIZATION

☐ Accept — I confirm that all of the information above is true. I know that I can lose my insurance if I give false information. I may also face disciplinary and legal charges. I understand that if my dependent loses eligibility, coverage will terminate at the end of the month in which the loss of eligibility occurs. I further understand that it is my responsibility to notify my benefits coordinator of the loss of eligibility and I will be held responsible for any claims paid in error for any reason. I authorize my employer to take deductions from my paycheck to pay for my benefit costs. Finally, I authorize healthcare providers to give my insurance carrier the medical and insurance records for me and my dependents.

☐ Refuse — I have been given the opportunity by my employer to apply for the group insurance program and have decided not to take advantage of this offer. I understand that if I later wish to apply, I or my dependents will have to provide proof of a special qualifying event or wait until annual enrollment.

| EMPLOYEE SIGNATURE | DATE | HOME PHONE (REQUIRED) | EMAIL ADDRESS (REQUIRED) |
|---|---|---|---|
| | | | |

## AGENCY SECTION — RETURN THIS FORM TO YOUR AGENCY BENEFITS COORDINATOR

| ORIGINAL HIRE DATE | COVERAGE BEGIN/END DATE | POSITION NUMBER | EDISON ID | NOTES TO BENEFITS ADMINISTRATION |
|---|---|---|---|---|
| | | | | ☐ PPACA Eligible ☐ 1450 Eligible |

| AGENCY BENEFITS COORDINATOR SIGNATURE | DATE |
|---|---|
| | |

**Active employees should return this completed form to your agency benefits coordinator. COBRA participants should send to Benefits Administration.**