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: Dental

EEW-13

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

GROUP NO. 123347 | SUBGROUP NO. | DEPARTMENT NO. | GROUP NAME: Tusculum College

COVERAGE EFFECTIVE DATE: Medical 04/01/2014 Dental 04/01/2014

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 Dependent 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: Dental Option: ❑ 1 ❑ Ind ❑ Fam ❑ EE/Spouse ❑ EE/Child(ren)

EMPLOYEE LAST NAME | EMPLOYEE FIRST NAME | MI | JR., SR., ETC. | SOCIAL SECURITY NO.** | DATE OF BIRTH ___/___/_____ | Male ❑ Female ❑

ADDRESS

❑ **SPANISH IS MY PRIMARY HOUSEHOLD LANGUAGE**

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

PAID CLASSIFICATION
❑ Hourly ❑ Salary

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

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 Social Security Number. ***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. 1 2 3 3 4 7 EMPLOYEE LAST NAME EMPLOYEE FIRST NAME **EEW-13**

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 ❑ | SOCIAL SECURITY NO.**

HAS SPOUSE HAD CONTINUOUS HEALTH COVERAGE FOR THE PAST 12 MONTHS? ❑ YES ❑ NO IF NO, WHAT ARE THE DATES OF MOST RECENT COVERAGE? From: / / To: / /

(1) DEPENDENT LAST NAME | DEPENDENT FIRST NAME | MI | JR., SR., ETC. | DATE OF BIRTH | Male ❑ Female ❑ | SOCIAL SECURITY NO.**

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

HAS DEPENDENT HAD CONTINUOUS HEALTH COVERAGE FOR THE PAST 12 MONTHS? ❑ YES ❑ NO IF NO, WHAT ARE THE DATES OF MOST RECENT COVERAGE? From: / / To: / /

(2) DEPENDENT LAST NAME | DEPENDENT FIRST NAME | MI | JR., SR., ETC. | DATE OF BIRTH | Male ❑ Female ❑ | SOCIAL SECURITY NO.**

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

HAS DEPENDENT HAD CONTINUOUS HEALTH COVERAGE FOR THE PAST 12 MONTHS? ❑ YES ❑ NO IF NO, WHAT ARE THE DATES OF MOST RECENT COVERAGE? From: / / To: / /

(3) DEPENDENT LAST NAME | DEPENDENT FIRST NAME | MI | JR., SR., ETC. | DATE OF BIRTH | Male ❑ Female ❑ | SOCIAL SECURITY NO.**

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

HAS DEPENDENT HAD CONTINUOUS HEALTH COVERAGE FOR THE PAST 12 MONTHS? ❑ YES ❑ NO IF NO, WHAT ARE THE DATES OF MOST RECENT COVERAGE? From: / / To: / /

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 ❑

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. 1 2 3 3 4 7 GROUP NAME Tusculum College

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.