

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/		
NEW ENROLLMENT (CHECK IF APPLICABLE):  New Hire  Open Enrollment  Rehire  Loss of Other Medical Cvg  Loss of Other Dental Cvg	□ COBRA OR □ STATE CONTINUATION: □ Termination of Employment □ Employee Eligible for Medicare	
□ Part-time change to Full-time □ Loss of Other Vision Cvg □ Marriage □ New Dependent Child Full-time Date of Hire: □ Loss of Other Vision Cvg □ Marriage □ New Dependent Child	(Voluntary or Involuntary)  Reduction in Hours  Dependent Child No Longer Eligible	
Court Order Other (FSA Only) Continuation Coverage Period Expired  Part-time / Rehire Date:  EVENT DATE: // // // // // // // // // // // // //	☐ Divorce/Legal Separation ☐ Death of Employee  EVENT DATE: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	
Section 2 - Employee/Member Information - Employee Must Complete In Full		
ELECT: Medical Option: 1 1 2 3 3 4 Other Ind	(ren)	
ELECT: Dental Option:		
ELECT: Vision Option:	medical/Medicare or dental insurance when this	
ELECT: FSA: Health Care: \$	are FSA □ Medical/Medicare □ Dental	
☐ Dependent Care: \$	HICN HICN	
EMPLOYEE LAST NAME         EMPLOYEE FIRST NAME         MI         JR., SR., ETC.         SSN/TIN**         DATE OF BIRTH         Male Female		
ADDRESS  SPANISH IS MY PRIMARY HOUSEHOLD LANGUAGE		
CITY (Please do not abbreviate)         STATE         ZIP         EMAIL ADDRESS***		
PAID CLASSIFICATION JOB TITLE  ☐ Hourly ☐ Salary ☐ Retiree ☐ Surviving Spouse ☐ Management ☐ Non-Management ☐ Exec/Officer/Owner	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, inclefrauding 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 was 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 medicany 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 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.	hich may be issued to me will be subject to all the terms and conditions of the Group al records pertaining to any person covered by the contract; 3) that I am responsible for	

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-1			
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			
BASIC LIFE INSURANCE AMT \$         00 OR   TIMES SALARY BENEFICIARY RELATIONSHIP PERCENTAGE BENEFICIARY RELATIONSHIP PERCENTAGE			
SUPPLEMENTAL LIFE/ADD AMT \$         .00   OR     TIMES SALARY   2   4			
LIFE/ADD AMT \$       .00 OR   TIMES SALARY   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  Other group medical coverage Other group vision coverage I have TennCare Other			
WAIVER SIGNATURE (Note: Signature also required in  EMPLOYEE LAST NAME			

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.