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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 [ No Place Like Home ]

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 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: 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\*    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

Dependent Care: \$ [ ] Annual Pledge Amount\*

**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 [ ]/[ ]/[ ] 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.

GROUP NO. \_\_\_\_\_

EMPLOYEE LAST NAME \_\_\_\_\_

EMPLOYEE FIRST NAME \_\_\_\_\_

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**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 US Able 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 \$ \_\_\_\_\_.

BASIC LIFE INSURANCE AMT	\$	_____	.00	OR	_____	TIMES SALARY	BENEFICIARY	RELATIONSHIP	PERCENTAGE	BENEFICIARY	RELATIONSHIP	PERCENTAGE
SUPPLEMENTAL LIFE/ADD AMT	\$	_____	.00	OR	_____	TIMES SALARY	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) \_\_\_\_\_ 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.