

801 Pine Street Chattanooga, TN 37402-2555 www.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	1
Rec:	l

EEW-05

Section 1 – Group / Employer Information – This form cannot be processed without this information
GROUP NO. SUBGROUP NO. DEPARTMENT NO. GROUP NAME COVERAGE EFFECTIVE DATE: M. M. D. D. Y. Y. M. M. D. D. Y
Medical Dental Dental
NEW ENROLLMENT (CHECK IF APPLICABLE): Outlifying Event: New Hire Open Enrollment Rehire Part-time change to Full-time Date of Hire: Hrs Wkd/Wk Part-time / Rehire Date: M M D D Y Y Y EVENT DATE: OUALIFYING EVENT: U COBRA OR STATE CONTINUATION: Termination of Employment (Voluntary) or Involuntary) Dependent Child Divorce / Legal Separation Dependent Child Divorce / Legal Separation Dependent Child Separation Dependent Child Separation Dependent Child Separation Dependent Child Separation Divorce / Legal Separation Dependent Child Separation Divorce / Legal Separation Dependent Child Separation
Section 2 - Employee / Member Information - Employee Must Complete In Full
ELECT: Medical Option:
(1) EMPLOYEE LAST NAME EMPLOYEE FIRST NAME MI JR., SR., ETC. SOCIAL SECURITY NO.* PAYROLL NO.
Médicare insurance when this plan goes into effect, indicate which coverage. Médicare insurance when this plan goes into effect, indicate which coverage. Dental
CITY (Please do not abbreviate) STATE ZIP DATE OF BIRTH Male Female JOB TITLE HICN HICN From: M M D D Y Y Y Y To: M M D D Y Y Y To: M M D D Y Y To: M M M D D Y To: M M D D Y Y To: M M M D D Y
(2) SPOUSE LAST NAME SPOUSE FIRST NAME MI JR., SR., ETC. Male Female DATE OF BIRTH 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?
(3) DEPENDENT LAST NAME DEPENDENT FIRST NAME MI JR., SR., ETC. Male Female DATE OF BIRTH SOCIAL SECURITY NO.^
□ Natural Child / Stepchild □ Adopted / Legal Guardian Other (specify) □ Physically □ Handicapped □ Over 19 From: To: □ M, M, D, D, Y, Y, M, M, D, D, Y, Y, Y, M, M, D, D, Y, Y, Y, M, M, D, D, Y,
HAS DEPENDENT HAD CONTINUOUS HEALTH COVERAGE FOR THE PAST 12 MONTHS? YES NO IF NO, WHAT ARE THE DATES OF MOST RECENT COVERAGE?
Section 4 – 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 and that; 3) I am responsible for any fee for these records.
Employee's Signature: Date: Date: Daytime Telephone No.: Area Code (Area Code)

GROUP NO. EMPLOYEE LAST NAME E	MPLOYEE FIRST NAME EEW-05
Section 5 - Dependent Information (Continued from Section 3). Consult Employer Guidelines for Dependent Eligibility.	
(4) DEPENDENT LAST NAME DEPENDENT FIRST NAME MI JR., SR., ETC. Male	Female DATE OF BIRTH SOCIAL SECURITY NO.*
	hysically Fulltime Student andicapped Over 19 From: To:
·	HE DATES OF MOST RECENT COVERAGE?
(5) DEPENDENT LAST NAME DEPENDENT FIRST NAME MI JR., SR., ETC. Male	Female DATE OF BIRTH SOCIAL SECURITY NO.*
Adopted / Legal Guardian Other (specify)	hysically Fulltime Student andicapped
	HE DATES OF MOST RECENT COVERAGE?
(6) DEPENDENT LAST NAME DEPENDENT FIRST NAME MI JR., SR., ETC. Male	Female DATE OF BIRTH SOCIAL SECURITY NO.*
Adopted / Legal Guardian Other (specify)	hysically Fulltime Student andicapped Over 19 From: To:
HAS DEPENDENT HAD CONTINUOUS HEALTH COVERAGE FOR THE PAST 12 MONTHS? YES NO IF NO, WHAT ARE T	HE DATES OF MOST RECENT COVERAGE?
(7) DEPENDENT LAST NAME DEPENDENT FIRST NAME MI JR., SR., ETC. Male	Female DATE OF BIRTH SOCIAL SECURITY NO.*
	nysically Andicapped Fulltime Student From: M. M. D. D. Y. Y. M. M. D. D. Y.
HAS DEPENDENT HAD CONTINUOUS HEALTH COVERAGE FOR THE PAST 12 MONTHS? YES NO IF NO, WHAT ARE TI	HE DATES OF MOST RECENT COVERAGE?
Section 6 – Life Insurance Information (Life insurance and related products are underwritten by independent life insurance carriers) (If Bene	ficiary Percentage is left blank, benefits will be divided equally among beneficiaries.)
ELECT (Mark all that apply) Life Class Basic Life/ADD Dependent Life STD LTD	□ Supplemental Life/ADD ANNUAL SALARY \$
BASIC LIFE INSURANCE AMT \$ 00 OR TIMES SALARY	PERCENTAGE BENEFICIARY RELATIONSHIP PERCENTAGE
SUPPLEMENTAL 1	3
LIFE/ADD AMT \$.00 OR TIMES SALARY 2	4
Section 7 – Waiver of Coverage - Complete this section to waive coverage, however, your Employer may require an additional separ	rata waiver form
DECLINE COVERAGE – I understand that I have been offered, and have declined, coverage sponsored by my employer. Medical Dental Basic Life/ADD Dependent Life STD LTD Supplemental Life/ADD	Reason for declining: (Mark all that apply) Other group Other group I have medical coverage dental coverage TennCare Other
GROUP NO. GROUP NAME	WAIVER SIGNATURE (Note: Signature also required in Section 4
EMPLOYEE LAST NAME EMPLOYEE FIRST NAME EMPLOYEE DATE OF BIRTH	when electing any coverage) X DATE

Special Enrollment Period for Medical and Dental: 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 may also enroll at the next Open Enrollment Period.