Fax To: 901-758-3021 or Mail To: 661 N Ericson Rd. Cordova TN 38018

ENROLLMENT APPLICATION/CHANGE FORM

Applications are accepted for the following three events:

1. **New Hire – 60 days from your eligibility date, the date your employer makes a contribution for you**
2. **Qualifying Life Event – 30 days from a Qualifying Life Event (marriage, birth of a child)**
3. **Plans Annual Open Enrollment Period**

SECTION 1: ENROLLMENT TYPE – Check All That Apply

☐ New Enrollee ☐ Add Dependent ☐ Open Enrollment ☐ Re-Enrollment

Are you enrolling due to a Qualifying Life Event? ☐ No ☐ Yes

Date of Event _____/_____/_____

EVENT TYPE: ☐ Marriage ☐ Birth ☐ Court Order ☐ Adoption

☐ Loss of Other Coverage ☐ Other (Explain): _____

☐ Waiving Coverage, Complete Section 2

SECTION 2: WAIVING COVERAGE

I would like to waive Dental Coverage Only ☐ YES

I would like to waive Medical and Dental Coverage ☐ YES

If you elect to waive coverage you cannot re-enroll until the next Annual Open Enrollment period unless you experience a Qualifying Life Event.

SECTION 3: EMPLOYEE'S INFORMATION

First Name	Last Name	Social Security #	Date of Birth

Mailing Address (Street) **City** **State** **Zip Code**

Gender	Phone Number	Email Address	Name of Employer(s)	Are you Retired from any Employer?
MALE / FEMALE				☐ Yes, Date of Retirement___/__/____ ☐ No

SECTION 4: PLAN OPTIONS --- Reference "Eligibility Criteria" to know your options. You can only elect a Plan Change During Open Enrollment

☐ Plan A, only those employees previously qualified for Plan A can elect Plan A

☐ Plan B, only those employees previously qualified for Plan A or Plan B can elect Plan B

☐ Plan C, only those employees previously qualified for Plan A, Plan B or Plan C can elect Plan C

*Applicable weekly copay premiums apply for each plan and are subject to change

SECTION 5: WHO ARE YOU ADDING OR REMOVING? *Only Full-Time Employees Can Add Dependents

First Name	Last Name	Relationship (Spouse/Child…)	Social Security #	Date of Birth	Gender	Are you Adding or Removing?	Date of Event

SECTION 6: COORDINATION OF BENEFITS (COB):

Do you or anyone you would like to add to this Plan have other health insurance? Yes ☐ or No ☐ If you answer yes, please complete section below. If the other coverage has terminated, you must submit a letter of credible coverage to the benefits office listed above. You are responsible for requesting this letter from the other insurance provider. If you answer "Yes" please attached a copy of that Provider's COB rules

Name of Insurance Company: _____ Effective Date: _____Policy Holder's Name:_____

Name of Covered Individuals: _____Benefits Included in Other Coverage: Medical ☐ Dental ☐

If Medicare ☐ Part A ☐ Part B ☐ Part D Medicare Effect Date: Medicare HICN:

Reason for Medicare Entitlement: ☐ Age ☐ Disability ☐ End Stage Renal Disease

Initial if you would like to Opt-In to receiving email and or text communication from the Fund _____

ACKNOWLEDGMENT and AUTHORIZATION

I understand any material misrepresentation will result in the cancellation of my coverage and the denial of claims plus reimbursement to the health plan of any benefit payments.

I understand my weekly premium cost, including potential arrears (back-pay) will not be reimbursed if I fail to complete the proper forms within the required timelines.

-I agree it is my responsibility to check my earnings statement each month to verify my benefit deductions and alert the Administration office immediately of errors. Further, I understand I will not be refunded deductions if I fail to provide this notification.

-I understand that my benefits can only be changed during open enrollment or a qualifying life event.

-I understand it is my responsibility to notify the plan of dependents that are no longer eligible within the required timelines

Signature: _____ Date: _____