VISION INSURANCE ENROLLMENT/CHANGE FORM

NEW ENROLLMENT:

Choose one: ☐ New Employee Coverage ☐ Open Enrollment ☐ Change in Status (See documentation information below)

Effective Date: ***(If Open Enrollment, effective date is January 1)***

TERMINATION:

Check all that apply: ☐ Terminate employee coverage ☐ Terminate spouse coverage ☐ Terminate child coverage

Effective Date***:*** ***(If Open Enrollment, effective date is December 31)***

Reason for RequestedTermination: (See documentation information below)

Required documentation: KCS dental insurance premiums are deducted from payroll before taxes. Therefore, IRS regulations require documentation of a change in status allowing enrollment or termination. Documentation must be provided with this form unless it is the open enrollment period (September 15-October 15 annually) or employee is within the first 31 days of their employment.

Employee Information:

First Name Middle Initial Last Name

Social Security # *(Social Security Number is required to process insurance cards)*

Sex ☐ Male ☐ Female Date of Birth Phone Number

Street or Mailing Address

City State Zip

Spouse Information (only required if enrolling or terminating coverage) :

First Name Middle Initial Last Name

Sex ☐ Male ☐ Female Date of Birth

Child Information (only required if enrolling or terminating coverage) :

First Name Middle Initial Last Name

Sex ☐ Male ☐ Female Date of Birth

First Name Middle Initial Last Name

Sex ☐ Male ☐ Female Date of Birth

First Name Middle Initial Last Name

Sex ☐ Male ☐ Female Date of Birth

First Name Middle Initial Last Name

Sex ☐ Male ☐ Female Date of Birth

Employee Signature_____ **Date**_____

Return this form by mail or fax to:
Knox County Schools – Employee Benefits
UT Tower 5th Floor, P.O. Box 2188, Knoxville, TN
37901-2188 Office (865) 594-1686 Fax (865) 594-9523