



STATE OF TENNESSEE GROUP INSURANCE PROGRAM  
**ENROLLMENT CHANGE APPLICATION**  
 Knox County Schools - Benefits and Employee Relations Department  
 Post Office Box 2188 - Knoxville, TN 37901-2188 - Fax (865) 594-9523



**PART 1: ACTION REQUESTED — PLEASE SEE PAGE 3 FOR INSTRUCTIONS**

<b>TYPE OF ACTION</b> <input type="checkbox"/> Add coverage <input type="checkbox"/> Change coverage <b>Form not for cancellation</b>	<b>COVERAGE</b> <input type="checkbox"/> Health	<b>PARTICIPANTS AFFECTED</b> <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)	<b>REASON FOR THIS ACTION</b> <input type="checkbox"/> New Hire/Newly Eligible <input type="checkbox"/> Court Order <input type="checkbox"/> Other _____	<b>Life Event</b> <input type="checkbox"/> Marriage <input type="checkbox"/> Newborn <input type="checkbox"/> Legal Guardianship <input type="checkbox"/> Adoption	<b>Special Enrollment (also complete pg 3)</b> <input type="checkbox"/> Death <input type="checkbox"/> Divorce <input type="checkbox"/> Loss of Eligibility
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**PART 2: EMPLOYEE INFORMATION**

FIRST NAME	MI	LAST NAME	DATE OF BIRTH	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W
SOCIAL SECURITY NUMBER	EMPLOYING AGENCY		EMPLOYER GROUP: <input type="checkbox"/> HED <input type="checkbox"/> State <input type="checkbox"/> Local Ed <input type="checkbox"/> Local Gov		YOUR CURRENT STATUS <input type="checkbox"/> Active <input type="checkbox"/> COBRA
HOME ADDRESS		<input type="checkbox"/> UPDATE MY ADDRESS	CITY	ST	ZIP CODE
COUNTY					

**PART 3: HEALTH COVERAGE SELECTION — CHOOSE CAREFULLY. EXCEPT FOR QUALIFYING EVENTS, CHANGES ARE NOT ALLOWED OUTSIDE THIS PLAN'S ANNUAL ENROLLMENT.**

<b>SELECT AN OPTION</b> <input type="checkbox"/> Premier PPO <input type="checkbox"/> Standard PPO	<b>LOCAL ED &amp; GOV ONLY MAY ALSO CHOOSE</b> <input type="checkbox"/> Limited PPO <input type="checkbox"/> Local CDHP/HSA	<b>SELECT A CARRIER &amp; NETWORK</b> <input type="checkbox"/> BCBS Network S <input type="checkbox"/> BCBS Network P* <input type="checkbox"/> Cigna LocalPlus <input type="checkbox"/> Cigna Open Access* *higher premium applies	<b>SELECT A HEALTH PREMIUM LEVEL</b> <input type="checkbox"/> employee only <input type="checkbox"/> employee + child(ren) <input type="checkbox"/> employee + spouse <input type="checkbox"/> employee + spouse + child(ren)
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**PART 7: DEPENDENT INFORMATION — ATTACH A SEPARATE SHEET IF NECESSARY**

NAME (FIRST, MI, LAST)	DATE OF BIRTH	RELATIONSHIP	GENDER	ACQUIRE DATE *	SOCIAL SECURITY NUMBER	HEALTH		
			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/>		
			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/>		
			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/>		

\* The acquire date is the date of marriage, birth, adoption or guardianship.  
 Proof of a dependent's eligibility must be submitted with this application for all new dependents (see page 2).  A separate sheet with more dependents is attached

**PART 8: EMPLOYEE AUTHORIZATION**

**Accept** I confirm that the information above is true. I understand my health, dental and vision selections are effective until the end of the plan year (December 31) subject to plan eligibility criteria, and that I cannot change insurance plans or carriers during the plan year. If I experience a qualifying event mid-year, I may be eligible for changes in enrollment of plan members and dependents as a special enrollment. I understand that submission of fraudulent information may lead to consequences including cancellation of insurance, disciplinary action from my employer, or possible criminal penalties. I understand that if my dependent loses eligibility, it is my responsibility to notify my benefits coordinator, and coverage will terminate at the end of the month in which the loss of eligibility occurs. I understand that I will be held responsible for any claims paid in error.

**Refuse** I have been given the opportunity by my employer to apply for the group insurance program and have decided not to take advantage of this offer. I understand that if I later wish to apply, I or my dependents will have to provide proof of a special qualifying event or wait until annual enrollment.

EMPLOYEE SIGNATURE	DATE	HOME PHONE (REQUIRED)	EMAIL ADDRESS (REQUIRED)
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**AGENCY SECTION — RETURN THIS FORM TO YOUR AGENCY BENEFITS COORDINATOR**

ORIGINAL HIRE DATE	COVERAGE BEGIN DATE	POSITION NUMBER	EDISON ID	NOTES TO BENEFITS ADMINISTRATION  <input type="checkbox"/> PPACA Eligible <input type="checkbox"/> 1450 Eligible
AGENCY BENEFITS COORDINATOR SIGNATURE			DATE	

Active employees should return this completed form to your agency benefits coordinator. COBRA participants should send to Benefits Administration.