HOLSTON CONFERENCE - UNITED METHODIST CHURCH - HEALTH INSURANCE ENROLLMENT FORM

CHURCH / ORGANIZATION TO BE BILLED ______________________ **EFFECTIVE DATE** ____________

CLERGY ☐ **LAY EMPLOYEE** ☐

QUALIFYING EVENT

NEW HIRE **DATE OF HIRE** / / ☐ **LOSS OF OTHER COVERAGE** ☐

TRANSITION FROM PART-TIME TO FULL-TIME ☐ **OPEN ENROLLMENT** ☐ **OTHER** ______ (SPECIFY) ☐

EMPLOYEE LAST NAME | **EMPLOYEE FIRST NAME** | **MI** | **SOCIAL SECURITY NBR.** | **DATE OF BIRTH** - - | **M** | **F**

ADDRESS

CITY | **STATE** | **ZIP CODE** | **EMAIL ADDRESS**

HEALTH PLAN *BCBST* NETWORK OPTIONS FOR TENNESSEE PROVIDERS ONLY

NETWORK "S" ☐ NETWORK "P" ☐

HEALTH PLAN COVERAGE OPTIONS (PLEASE SELECT ONE)

INDIVIDUAL ☐ EMPLOYEE+ SPOUSE OR + ONE CHILD ☐ FAMILY ☐

HEALTH PLAN BENEFIT OPTIONS (PLEASE SELECT ONE)

Regular PPO Plan ☐

HEALTH SAVINGS ACCOUNT PLAN (3) ☐
(SAVINGS ACCOUNT INFORMATION REQUIRED)

H.S.A With _: HEALTH EQUITY.COM ☐ HMFCU ☐ A/C # ____________

DO YOU WISH TO ENROLL IN THE OPTIONAL DENTAL COVERAGE AT NO ADDITIONAL PREMIUM? **YES** ☐ NO ☐

DO YOU WISH TO ENROLL IN THE OPTIONAL VISION COVERAGE WITH ADDITIONAL PREMIUM? **YES** ☐ NO ☐ S ☐ E+1 ☐ F ☐

ACKNOWLEDGEMENT

I understand, and agree, that I am applying for coverage in the Holston Conference Self-Insured Health Plan administered by Blue Cross/Blue Shield of Tennessee and that my signature on this form will authorize any doctor, hospital, or other provider of treatment to furnish Blue Cross/Blue Shield of Tennessee any and all medical records pertaining to any person covered by this contract.

I WILL BE COVERED BY ANOTHER HEALTH PLAN AVAILABLE TO ME AND DECLINE COVERAGE AT THIS TIME ☐

EMPLOYEE SIGNATURE________________________ DATE - - PHONE - -

revised 1-1-2017

PLEASE COMPLETE PAGE 2 FOR ALL DEPENDENTS TO BE COVERED UNDER THIS PLAN

DEPENDENT INFORMATION - PLEASE PROVIDE ALL INFORMATION FOR EACH PERSON TO BE COVERED

SPOUSE LAST NAME **SPOUSE FIRST NAME** **MI** **SOCIAL SECURITY NBR.** **DATE OF BIRTH** **M** **F**

HAS SPOUSE HAD CONTINUOUS HEALTH COVERAGE FOR THE PAST 12 MONTHS? YES ☐ NO ☐

IF NO, WHAT ARE THE DATES OF MOST RECENT COVERAGE ? FROM - - TO - -

DEPENDENT LAST NAME **DEPENDENT FIRST NAME** **MI** **SOCIAL SECURITY NBR.** **DATE OF BIRTH** **M** **F**

NATURAL CHILD / STEP CHILD ☐ ADOPTED / LEGAL GUARDIAN ☐ OTHER (SPECIFY)________________________________ ☐

HAS DEPENDENT HAD CONTINUOUS HEALTH COVERAGE FOR THE PAST 12 MONTHS? YES ☐ NO ☐

IF NO, WHAT ARE THE DATES OF MOST RECENT COVERAGE ? FROM - - TO - -

DEPENDENT LAST NAME **DEPENDENT FIRST NAME** **MI** **SOCIAL SECURITY NBR.** **DATE OF BIRTH** **M** **F**

NATURAL CHILD / STEP CHILD ☐ ADOPTED / LEGAL GUARDIAN ☐ OTHER (SPECIFY)________________________________ ☐

HAS DEPENDENT HAD CONTINUOUS HEALTH COVERAGE FOR THE PAST 12 MONTHS? YES ☐ NO ☐

IF NO, WHAT ARE THE DATES OF MOST RECENT COVERAGE ? FROM - - TO - -

DEPENDENT LAST NAME **DEPENDENT FIRST NAME** **MI** **SOCIAL SECURITY NBR.** **DATE OF BIRTH** **M** **F**

NATURAL CHILD / STEP CHILD ☐ ADOPTED / LEGAL GUARDIAN ☐ OTHER (SPECIFY)________________________________ ☐

HAS DEPENDENT HAD CONTINUOUS HEALTH COVERAGE FOR THE PAST 12 MONTHS? YES ☐ NO ☐

IF NO, WHAT ARE THE DATES OF MOST RECENT COVERAGE ? FROM - - TO - -

DEPENDENT LAST NAME **DEPENDENT FIRST NAME** **MI** **SOCIAL SECURITY NBR.** **DATE OF BIRTH** **M** **F**

NATURAL CHILD / STEP CHILD ☐ ADOPTED / LEGAL GUARDIAN ☐ OTHER (SPECIFY)________________________________ ☐

HAS DEPENDENT HAD CONTINUOUS HEALTH COVERAGE FOR THE PAST 12 MONTHS? YES ☐ NO ☐

IF NO, WHAT ARE THE DATES OF MOST RECENT COVERAGE ? FROM - - TO - -

USE ADDITIONAL SHEETS IF NECESSARY