TENNESSEE CONFERENCE HEALTH PLAN ENROLLMENT FORM

☐ Open Enrollment ☐ New Hire	☐ ADDRESS CHANGE ONLY ☐ Late Enrollee	☐ Special Enrollee	☐ Change (indicate event requiring contract change below)

Name (Last)▼ (First)▼ (M)▼	Social Security No.▼	Soc. Sec. Disabled?	Medicare Enrolled?	Birth Date▼	Gender
		☐ Yes ☐ No	☐ Yes ☐ No		☐ Female ☐ Male
Address ►	EMAIL ADDRESS▼		Telephone No.▼	Marital Status:	
City, State, Zip►				☐ Single ☐ Married	
Employment Status: ☐ Full-Time ☐ Part-Time (Approved Student Pastors Only) ☐ COBRA	Date of Hire:	Medical Coverage for: ☐ Employee Only ☐ Spouse Only ☐ Children Only ☐ Family		Effective Date of Coverage:	

Dependent Name (First, MI, Last)	**Social Security No.**	**Birth Date**	**Gender**	**Full-Time Student?**
Spouse			☐ M ☐ F	☐ Yes ☐ No
Dependent			☐ M ☐ F	☐ Yes ☐ No
Dependent			☐ M ☐ F	☐ Yes ☐ No
Dependent			☐ M ☐ F	☐ Yes ☐ No

Event Requiring Contract Change: ☐ Marriage ☐ Birth/Adoption ☐ Divorce ☐ Other

I HEREBY REQUEST to be covered and authorize deductions, if any, from my wages for my share of the benefits for which I am eligible or may be entitled, under the coverage elected on this form.

► **Signature** ______________________________ **Date** ______________________________

Other Coverage Information – If your spouse or anyone named on this application has medical coverage through another company where the employer pays any portion of the cost or makes payroll deductions, please complete the following:

Name (First, MI, Last)	Employer
Insurance Company Name	Policy No.
Insurance Company Address (City, State, Zip)	Contract Type ☐ Medical Single ☐ Medical Family

WAIVER OF COVERAGE

I, the undersigned, hereby certify that I have been given an opportunity to enroll in the group plan sponsored by my employer. After careful consideration, I have elected not to participate in the following coverage(s). I further understand that should I decided to participate at a future date, I may have to furnish satisfactory evidence of insurability for myself and, if applicable, any eligible dependents. If I am declining enrollment for myself or my dependents (including my spouse) because of other insurance coverage, I understand that I may, in the future, be able to enroll myself or my dependents in this plan, provided that I request enrollment within 30 days after my other coverage ends. In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

☐ Employee Medical ☐ Dependent Medical

Signature **Date**

▲ SIGN HERE IF YOU ARE WAIVING COVERAGE