

**EMPLOYEE ENROLLMENT / WAIVER**  
 PLEASE USE BLUE OR BLACK INK ONLY  
 IF YOU ARE DECLINING COVERAGE, PLEASE GO TO BACK OF FORM.

**Plan Use Only**  
 Rec: \_\_\_\_\_

**Section 1 - Group / Employer Information - This form cannot be processed without this information**

GROUP NO. \_\_\_\_\_ SUBGROUP NO. \_\_\_\_\_ DEPARTMENT NO. \_\_\_\_\_ GROUP NAME O.R. NURSES, INC

COVERAGE EFFECTIVE DATE: \_\_\_\_\_

Medical \_\_\_\_\_ Dental \_\_\_\_\_

**NEW ENROLLMENT (CHECK IF APPLICABLE):**

New Hire  Open Enrollment  Rehire  Part-time change to Full-time  Reduction in Hours

Full-time Date of Hire: \_\_\_\_\_ Part-time / Rehire Date: \_\_\_\_\_

**QUALIFYING EVENT:**

Marriage  New Dep Child  Loss of Other Medical Cvg  Loss of Other Dental Cvg  Court Order

**COBRA OR STATE CONTINUATION:**

Termination of Employment (Voluntary or Involuntary)  Employee Eligible for Medicare

Dependent Child  Divorce / Legal Separation

No Longer Eligible  Other \_\_\_\_\_

Event Date: \_\_\_\_\_

**Section 2 - Employee / Member Information - Employee Must Complete In Full**

ELECT: Medical Option:  1  2  3  4 Other \_\_\_\_\_

ELECT: Dental Option:  1  2  3  4 Other \_\_\_\_\_

(1) EMPLOYEE LAST NAME \_\_\_\_\_ EMPLOYEE FIRST NAME \_\_\_\_\_ MI \_\_\_\_\_ JR., SR., ETC. \_\_\_\_\_ SOCIAL SECURITY NO.\* \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY (Please do not abbreviate) \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

PAID CLASSIFICATION:  Hourly  Salary  Retiree  Surviving Spouse

JOB CLASSIFICATION:  Management  Non-Management  Exec/Officer/Owner

PAYROLL NO. \_\_\_\_\_

OTHER INSURANCE:  Medicare/Medicare  Dental

If you or listed dependents will be covered by other health, dental or Medicare insurance when this plan goes into effect, indicate which coverage.

**HAVE YOU HAD CONTINUOUS HEALTH COVERAGE FOR THE PAST 12 MONTHS?**  YES  NO **IF NO, WHAT ARE THE DATES OF MOST RECENT COVERAGE?**

**Section 3 - Dependent Information - Please provide all information for each person to be covered. LIST ADDITIONAL DEPENDENTS ON BACK. Consult Employer Guidelines for Dependent Eligibility.**

(2) SPOUSE LAST NAME \_\_\_\_\_ SPOUSE FIRST NAME \_\_\_\_\_ MI \_\_\_\_\_ JR., SR., ETC. \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

Male  Female

DATE OF BIRTH \_\_\_\_\_

Male  Female

SOCIAL SECURITY NO.\* \_\_\_\_\_

**HAS SPOUSE HAD CONTINUOUS HEALTH COVERAGE FOR THE PAST 12 MONTHS?**  YES  NO **IF NO, WHAT ARE THE DATES OF MOST RECENT COVERAGE?**

(3) DEPENDENT LAST NAME \_\_\_\_\_ DEPENDENT FIRST NAME \_\_\_\_\_ MI \_\_\_\_\_ JR., SR., ETC. \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

Male  Female

DATE OF BIRTH \_\_\_\_\_

Male  Female

SOCIAL SECURITY NO.\* \_\_\_\_\_

Natural Child / Stepchild  Adopted / Legal Guardian  Other (specify) \_\_\_\_\_

Physically Handicapped

Fulltime Student

Over 19

**Section 4 - Acknowledgement - Signature and Date MUST BE COMPLETED**

Employee should notify BlueCross BlueShield of Tennessee if any dependent's address is different from the employee's address. It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of coverage. I understand, and agree, that I am applying for coverage and: 1) that any contract which may be issued to me will be subject to all the terms and conditions of the Group Agreement; 2) that my signature on this form will authorize any doctor, hospital, or other provider of treatment to furnish BlueCross BlueShield of Tennessee any and all medical records pertaining to any person covered by the contract and that; 3) I am responsible for any fee for these records.

Employee's Signature: X \_\_\_\_\_ Date: \_\_\_\_\_

Daytime Contact No. X \_\_\_\_\_

SPANISH IS MY PRIMARY HOUSEHOLD LANGUAGE

\* To comply with Federal regulations we must have Social Security Number \_\_\_\_\_

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APP-EEW (7/06)

GROUP NO. EMPLOYEE LAST NAME EMPLOYEE FIRST NAME SOCIAL SECURITY NO.

Section 5 - Dependent information (Continued from Section 3). Consult Employer Guidelines for Dependent Eligibility.

(4) DEPENDENT LAST NAME DEPENDENT FIRST NAME MI JR., SR., ETC. DATE OF BIRTH SOCIAL SECURITY NO. \*
Other (specify)
Physically Handicapped
Fulltime Student
Over 19

(5) DEPENDENT LAST NAME DEPENDENT FIRST NAME MI JR., SR., ETC. DATE OF BIRTH SOCIAL SECURITY NO. \*
Other (specify)
Physically Handicapped
Fulltime Student
Over 19

(6) DEPENDENT LAST NAME DEPENDENT FIRST NAME MI JR., SR., ETC. DATE OF BIRTH SOCIAL SECURITY NO. \*
Other (specify)
Physically Handicapped
Fulltime Student
Over 19

(7) DEPENDENT LAST NAME DEPENDENT FIRST NAME MI JR., SR., ETC. DATE OF BIRTH SOCIAL SECURITY NO. \*
Other (specify)
Physically Handicapped
Fulltime Student
Over 19

(8) DEPENDENT LAST NAME DEPENDENT FIRST NAME MI JR., SR., ETC. DATE OF BIRTH SOCIAL SECURITY NO. \*
Other (specify)
Physically Handicapped
Fulltime Student
Over 19

(9) DEPENDENT LAST NAME DEPENDENT FIRST NAME MI JR., SR., ETC. DATE OF BIRTH SOCIAL SECURITY NO. \*
Other (specify)
Physically Handicapped
Fulltime Student
Over 19

(10) DEPENDENT LAST NAME DEPENDENT FIRST NAME MI JR., SR., ETC. DATE OF BIRTH SOCIAL SECURITY NO. \*
Other (specify)
Physically Handicapped
Fulltime Student
Over 19

(11) DEPENDENT LAST NAME DEPENDENT FIRST NAME MI JR., SR., ETC. DATE OF BIRTH SOCIAL SECURITY NO. \*
Other (specify)
Physically Handicapped
Fulltime Student
Over 19

(12) DEPENDENT LAST NAME DEPENDENT FIRST NAME MI JR., SR., ETC. DATE OF BIRTH SOCIAL SECURITY NO. \*
Other (specify)
Physically Handicapped
Fulltime Student
Over 19

(13) DEPENDENT LAST NAME DEPENDENT FIRST NAME MI JR., SR., ETC. DATE OF BIRTH SOCIAL SECURITY NO. \*
Other (specify)
Physically Handicapped
Fulltime Student
Over 19

(14) DEPENDENT LAST NAME DEPENDENT FIRST NAME MI JR., SR., ETC. DATE OF BIRTH SOCIAL SECURITY NO. \*
Other (specify)
Physically Handicapped
Fulltime Student
Over 19

(15) DEPENDENT LAST NAME DEPENDENT FIRST NAME MI JR., SR., ETC. DATE OF BIRTH SOCIAL SECURITY NO. \*
Other (specify)
Physically Handicapped
Fulltime Student
Over 19

(16) DEPENDENT LAST NAME DEPENDENT FIRST NAME MI JR., SR., ETC. DATE OF BIRTH SOCIAL SECURITY NO. \*
Other (specify)
Physically Handicapped
Fulltime Student
Over 19

(17) DEPENDENT LAST NAME DEPENDENT FIRST NAME MI JR., SR., ETC. DATE OF BIRTH SOCIAL SECURITY NO. \*
Other (specify)
Physically Handicapped
Fulltime Student
Over 19

(18) DEPENDENT LAST NAME DEPENDENT FIRST NAME MI JR., SR., ETC. DATE OF BIRTH SOCIAL SECURITY NO. \*
Other (specify)
Physically Handicapped
Fulltime Student
Over 19

(19) DEPENDENT LAST NAME DEPENDENT FIRST NAME MI JR., SR., ETC. DATE OF BIRTH SOCIAL SECURITY NO. \*
Other (specify)
Physically Handicapped
Fulltime Student
Over 19

(20) DEPENDENT LAST NAME DEPENDENT FIRST NAME MI JR., SR., ETC. DATE OF BIRTH SOCIAL SECURITY NO. \*
Other (specify)
Physically Handicapped
Fulltime Student
Over 19

(21) DEPENDENT LAST NAME DEPENDENT FIRST NAME MI JR., SR., ETC. DATE OF BIRTH SOCIAL SECURITY NO. \*
Other (specify)
Physically Handicapped
Fulltime Student
Over 19

(22) DEPENDENT LAST NAME DEPENDENT FIRST NAME MI JR., SR., ETC. DATE OF BIRTH SOCIAL SECURITY NO. \*
Other (specify)
Physically Handicapped
Fulltime Student
Over 19

(23) DEPENDENT LAST NAME DEPENDENT FIRST NAME MI JR., SR., ETC. DATE OF BIRTH SOCIAL SECURITY NO. \*
Other (specify)
Physically Handicapped
Fulltime Student
Over 19

(24) DEPENDENT LAST NAME DEPENDENT FIRST NAME MI JR., SR., ETC. DATE OF BIRTH SOCIAL SECURITY NO. \*
Other (specify)
Physically Handicapped
Fulltime Student
Over 19

Section 6 - Life Insurance Information

Life insurance and related products are underwritten by independent life insurance carriers. (If Beneficiary Percentage is left blank, benefits will be divided equally among beneficiaries.)
ELECT (Mark all that apply) Life Class Basic Life/ADD Dependent Life LTD STD Supplemental Life/ADD ANNUAL SALARY PERCENTAGE BENEFICIARY RELATIONSHIP PERCENTAGE
INSURANCE AMT \$ .00 OR TIMES SALARY
SUPPLEMENTAL LIFE/ADD AMT \$ .00 OR TIMES SALARY

Section 7 - Waiver of Coverage - Complete this section to waive coverage, however, your Employer may require an additional separate waiver form.

DECLINE COVERAGE - I understand that I have been offered, and have declined, coverage sponsored by my employer.
Reason for declining: (Mark all that apply)
Other group I have
Other group dental coverage TennCare Other
medical coverage dental coverage TennCare Other

GROUP NO. GROUP NAME

EMPLOYEE LAST NAME EMPLOYEE FIRST NAME EMPLOYEE DATE OF BIRTH WAIVER SIGNATURE (Note: Signature also required in Section 4 when electing any coverage) DATE

Special Enrollment Period for Medical and Dental: An Employee or eligible dependent who did not apply for Coverage within thirty-one (31) days of first becoming eligible for Coverage under this Plan may enroll if: 1) he or she had other health care coverage at the time Coverage under this plan was previously offered; and 2) he or she stated, in writing, at the time Coverage under this Plan was previously offered, that such other coverage was the reason for declining Coverage under this Plan; and 3) such other coverage is exhausted (if the other coverage was continuation coverage under COBRA) or the other coverage was terminated because he or she ceased to be eligible due to involuntary termination or employer contributions for such coverage ended; and 4) he or she applies for coverage under this Plan and the administrator receives the change form within thirty-one (31) days after the loss of other coverage. The Employee may also enroll at the next Open Enrollment Period.