

GROUP NO. [] EMPLOYEE LAST NAME [] EMPLOYEE FIRST NAME []

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. [] Male Female DATE OF BIRTH [] SOCIAL SECURITY NO.* []
M M D D Y Y Y Y

Natural Child / Stepchild Adopted / Legal Guardian Other (specify) [] Physically Handicapped Fulltime Student Over 19 From: [] To: []

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

(5) DEPENDENT LAST NAME [] DEPENDENT FIRST NAME [] MI [] JR., SR., ETC. [] Male Female DATE OF BIRTH [] SOCIAL SECURITY NO.* []
M M D D Y Y Y Y

Natural Child / Stepchild Adopted / Legal Guardian Other (specify) [] Physically Handicapped Fulltime Student Over 19 From: [] To: []

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

(6) DEPENDENT LAST NAME [] DEPENDENT FIRST NAME [] MI [] JR., SR., ETC. [] Male Female DATE OF BIRTH [] SOCIAL SECURITY NO.* []
M M D D Y Y Y Y

Natural Child / Stepchild Adopted / Legal Guardian Other (specify) [] Physically Handicapped Fulltime Student Over 19 From: [] To: []

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

(7) DEPENDENT LAST NAME [] DEPENDENT FIRST NAME [] MI [] JR., SR., ETC. [] Male Female DATE OF BIRTH [] SOCIAL SECURITY NO.* []
M M D D Y Y Y Y

Natural Child / Stepchild Adopted / Legal Guardian Other (specify) [] Physically Handicapped Fulltime Student Over 19 From: [] To: []

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

Section 6 – Ancillary Insurance Information (NOTE: Products are offered by USAbLe Life or other carriers which are independent and solely responsible. These are NOT BlueCross BlueShield products.)

ELECT (Mark all that apply) Life Class [] Basic Life/ADD Dependent Life STD LTD Supplemental Life/ADD ANNUAL SALARY \$ [] .00

BASIC LIFE INSURANCE AMT	\$	[] .00	OR	[]	TIMES SALARY	BENEFICIARY	RELATIONSHIP	PERCENTAGE	BENEFICIARY	RELATIONSHIP	PERCENTAGE
SUPPLEMENTAL LIFE/ADD AMT	\$	[] .00	OR	[]	TIMES SALARY	1			3		
						2			4		

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.
 Medical Dental Basic Life/ADD Dependent Life STD LTD Supplemental Life/ADD FSA
 Reason for declining: (Mark all that apply)
 Other group medical coverage Other group dental coverage I have 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) X [] DATE []
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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.