Holston Conference UMC Health Insurance

2021 CHANGE REQUEST Form

Church/Organization: ______________________________

Employee Data (*please print*)

Employee Name (Last, First, M.I.) ______________________________

Employee Blue Cross Blue Shield 9-Digit ID Number ______________________________

Reason for Change

Open Enrollment **Effective Date** ____________________

Loss of Other Medical Coverage | Loss of Other Dental Coverage | Loss of Other Vision Coverage

Continuation Coverage Period Expired | Marriage | New Dependent Child | Court Order

Type of Change/Event Date: / /

Add/Change Dependent(s) | Add/Change Medical Coverage | Add/Change Dental Coverage

Add/Change Vision Coverage | Add/Change Health Care FSA | Add/Change Dependent Care FSA

Change Name/Date of Birth | Change Address/Phone No./Email | Change Church/Organization

Employee Name and Address Changes: (*Only Complete Areas You Need to Change in Name/Address section)*

New Address (Street, City, State, Zip) ______________________________

New Phone Number ______________________________

New E-mail Address ______________________________

New Name (Last, First, M.I.) ______________________________

New Church/Organization ______________________________

Select Health Plan Options

Choose Level of Coverage: Individual | E+1 | Family

Choose Network (Tennessee Providers Only): Network "S" | Network "P"

Choose Your Plan: PPO | HSA Account with: | Health Equity Acct. | HFMCU Acct #: ________________

Enroll in Dental Plan *at No Additional Charge*? Yes | No

Enroll in Vision Plan *with Additional Premium*? Individual ($11/mo) | E+1 ($18/mo) | Family ($27/mo)

Enroll in Flexible Spending Account? Yes ***(Must complete Progressive Benefit Solutions form)***

Medical Reimbursement Account Annual Amount: $______________

Dependent Care Reimbursement Account Annual Amount: $______________

Dependent Information: *(Additional dependents on separate sheet)*

Add / Remove Name Last, First, M.I., *Print please*) | Date of Birth | Social Security # | Sex M F | Vision Y N

Spouse | Natural Child/Stepchild | Adopted/Legal Guardian | Other ____________________ | Physically Handicapped

Add / Remove Name Last, First, M.I., *Print please*) | Date of Birth | Social Security # | Sex M F | Vision Y N

Spouse | Natural Child/Stepchild | Adopted/Legal Guardian | Other ____________________ | Physically Handicapped

Add / Remove Name Last, First, M.I., *Print please*) | Date of Birth | Social Security # | Sex M F | Vision Y N

Spouse | Natural Child/Stepchild | Adopted/Legal Guardian | Other ____________________ | Physically Handicapped

Have your spouse/dependents had continuous health care for the past 12 months? Yes | No

If no, what are the dates of most recent coverage? From ________________ to ________________

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.*

Employee Signature: ______________________________ Date Signed: ______________________________

Questions? email: *openenrollment@holston.org* or visit *www.holston.org/openenrollment*

Please send completed form(s) to the Holston Conference Benefits Office before November 15, 2020, by emailing them to ***openenrollment@holston.org*** or mailing them to **Holston Annual Conference, Attn: Open Enrollment, P.O. Box 850, Alcoa, TN, 37701**.