Holston Conference UMC Health Insurance

2021 NEW PARTICIPANT ENROLLMENT Form

Effective January 1, 2021

Church/Org. To Be Billed: ______________________________ **District:**________________ **Clergy** **Lay**

Reason for Enrollment

Effective Date ____________________

Open Enrollment **New Hire** (Date of hire: ____________________)

Qualifying Event: *Loss of Other Coverage* *Transition to full time* *Other* ____________________________

Employee Data (*please print*)

____

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

____________________ ____________________________ Sex M F

Date of Birth Social Security Number

____

Home Address – Street, City, State Zip Code

____________________ ____________________ ______________________________

Home/Cell Phone Work Phone E-mail Address

Health Plan

(a) Choose Your Level of Coverage: Individual E+1 Family

(b) Choose Your Network (Tennessee Providers Only): Network "S" Network "P"

(c) Choose Your Plan: PPO HSA ***Requires that you open a Health Savings Account at one of the following:*

Health Equity Acct HFMCU Acct #: ________________

(d) Choose Your Optional Coverages:

All Medical Plans include limited Dental Coverage

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

(e) Enroll in Flexible Spending Account Options through Progressive Benefit Solutions: *(Important: Additional Enrollment Form Required Every Year!)*

Medical Reimbursement Account Annual Amount: $______________

Dependent Care Reimbursement Account Annual Amount: $______________

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

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

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

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**.