

Enrollment Form

Complete when first eligible (newly hired) or at open enrollment if changing coverage

Section I: Employee Information

Employees, please fill out this page and return to your human resources department.

Last Name		First Name		MI	Social Security No.		Date of Birth		Gender		
					- -		/ /		M F		
Home Address				City		State	Zip	Phone Number			
								()			
Marital Status		Enrollment Type		Medical Benefit Selection			Level of Coverage				
<input checked="" type="checkbox"/>	Single	<input checked="" type="checkbox"/>	New Enrollee	<input checked="" type="checkbox"/>	Employee		<input checked="" type="checkbox"/>	Silver		<input checked="" type="checkbox"/>	Qualified High Deductible
<input checked="" type="checkbox"/>	Married	<input checked="" type="checkbox"/>	Rehire	<input checked="" type="checkbox"/>	Employee + One		<input checked="" type="checkbox"/>	Bronze		<input checked="" type="checkbox"/>	Office Visit Co-Pay
<input checked="" type="checkbox"/>	Divorced	<input checked="" type="checkbox"/>	Reinstatement of Coverage	<input checked="" type="checkbox"/>	Family		<input checked="" type="checkbox"/>	Waive Coverage			
<input checked="" type="checkbox"/>	Widowed	<input checked="" type="checkbox"/>	Special Enrollment	Waiving Coverage Under the Plan –I Understand that by choosing not to be covered under this Plan I may affect my ability to be covered at a later date. I will only be able to add coverage at open enrollment or as a Special Enrollee as described on the reverse.							
		<input checked="" type="checkbox"/>	Open Enrollment								

Please list all dependents that you want covered under the TICUA Benefit Consortium Health Care Plan. **Dependents include spouse and children.** Enrollment form must be completed for all dependents within 31 days of their becoming eligible for coverage.

Name	Gender	Birthdate	SSN	Relationship (Spouse, son, daughter, etc.)	If Dependent was covered under a prior plan, list original effective date of coverage.
Last Name, First Name M.I.				Spouse	
Last Name, First Name M.I.					
Last Name, First Name M.I.					
Last Name, First Name M.I.					

If you currently have other medical coverage, please complete this section.

Name of Primary Insured			SSN of Primary Insured			Date of Birth	
Last Name	First Name	M.I.					
Name of Employer				Employer Phone #		Circle Coverage Type	
				()		Single Family	
Name of Insurance Carrier →							

Other Natural Parent Information - If you are **divorced** and have a child, please enter other natural parent's information.

If you are divorced, does your child live with his or her other natural parent? → Yes No

If child does not live with you or other natural parent, please specify other living arrangement: →

Last Name		First Name		MI	Social Security No.		Date of Birth	
							/ /	
Home Address				City		State	Zip	Phone Number
								()
Place of Employment			Employer Address			Employer Phone No.		
						()		

Please provide the following to the human resources department at your institution

1. A copy of that portion of your divorce decree that mandates which party is to provide coverage for medical care for this dependent.
2. If this issue is **not** specified in your divorce decree, you **must** provide either (1) A copy of the legal assignment of Medical Care provided by a court **OR** (2) A notarized statement that you are principally responsible for the medical care of this dependent child.

I certify that the above is a complete statement of other medical care/coverage available for the above dependent.

Signature of Employee: _____ (Divorced Parent Signature Only)

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Full Time Student Certification – Please fill out this section for dependent children who are over age 24. A letter from the registrar’s office must be provided to your human resources representative.

Last Name	First Name	MI	Social Security No.	Date of Birth	Gender
				/ /	M F
Please specify what college, university, trade school, etc. dependent is attending: →					
Year Enrolled →	20__	Term Attending →	Spring	Summer	Fall
			Winter	Other:	

EMPLOYEE, PLEASE READ AND SIGN BELOW

SPECIAL ENROLLMENT: If an eligible Employee or Dependent declined health coverage hereunder at the time of initial eligibility (and stated in writing at the time that coverage was declined because of alternative health coverage) but subsequently loses coverage under the other health plan and makes application for coverage hereunder within 31 days of the loss, such individual shall be a Special Enrollee provided such person: (a) was under a COBRA continuation provision and the coverage under such provision was exhausted; or (b) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contribution toward such coverage were terminated. Individuals who lose other coverage due to nonpayment of premium, for cause (e.g., filing fraudulent claims) shall not be Special Enrollees hereunder. An eligible Employee or Dependent who seeks to enroll in the Plan as a result of the acquisition of a new Dependent through marriage, birth, adoption or placement for adoption shall be a Special Enrollee hereunder if the eligible Employee or Dependent enrolls within 31 days of the acquisition of the new Dependent. Coverage for a Special Enrollee (other than a newborn or newly adopted child) shall begin as of the date of the change. Coverage for a newly adopted or newborn Special Enrollee shall begin as of the day of the adoption, birth, or placement for adoption.

NOTICE OF PRE-EXISTING CONDITIONS EXCLUSION: The group health coverage you are applying for does not provide benefits for Pre-existing Conditions for a period of 12 months for persons who are enrolled when first eligible or who enroll during a Special Enrollment Period, or for a period of 18 months for persons who are Late Enrollees. This period may be reduced if you had previous Creditable Coverage and furnish the Plan with a Certificate of Creditable Coverage. Until this certification is received and a determination is made as to whether or not you are entitled to a reduced period of pre-existing conditions exclusions, any claim submitted for a pre-existing condition, incurred during the next 12 or 18 month periods, will be denied. If a Certificate, or other evidence of Creditable Coverage is subsequently received the claim will be reconsidered. If the above change is a termination of employment, you may be eligible for continued coverage under COBRA. Please review the stipulations set forth in your Plan Summary Document/Plan Description.

I hereby authorize any Hospital, Physician, Organization, Employer, Insurance Company or Administrator to release any information pertinent to my claims while covered under this Plan.

I hereby request all coverage indicated above for which I am or may become eligible under the TICUA Benefit Consortium, Inc. Health Plan. I authorize my employer to deduct from my earnings any contributions required of me for the payment of premiums for such coverage.

Employee’s Signature	Date Signed
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Section II: TO BE COMPLETED BY HUMAN RESOURCES ONLY

Employer, fill out this page and mail or fax both pages of the Enrollment Form to TICUA Benefit Consortium, 1031 17th Avenue South, Nashville, TN 37212, Fax (615) 292-3933.

College/University Name	Group No.	Employee Hire Date	Coverage Effective Date
Received Certificate of Creditable Coverage? →	Yes No	If Yes, then fax or mail the Certificate of Creditable Coverage along with this Enrollment form.	
Employer Certification: I certify that all the information included on this form is current and correct to the best of my knowledge.			
Employer Signature	Date Signed		

Employer Notes:
