

GROUP NO. EMPLOYEE LAST NAME EMPLOYEE FIRST NAME

EEW-15

Section 4 - Dependent Information - Please provide all information for each person to be covered. Consult employer guidelines for dependent eligibility.

SPOUSE LAST NAME SPOUSE FIRST NAME MI JR., SR., ETC. DATE OF BIRTH Male Female SSN/TIN**

(1) DEPENDENT LAST NAME DEPENDENT FIRST NAME MI JR., SR., ETC. DATE OF BIRTH Male Female SSN/TIN**

Natural Child/Stepchild Adopted/Legal Guardian Other (specify) Physically Handicapped Full-time Student Over 19

(2) DEPENDENT LAST NAME DEPENDENT FIRST NAME MI JR., SR., ETC. DATE OF BIRTH Male Female SSN/TIN**

Natural Child/Stepchild Adopted/Legal Guardian Other (specify) Physically Handicapped Full-time Student Over 19

(3) DEPENDENT LAST NAME DEPENDENT FIRST NAME MI JR., SR., ETC. DATE OF BIRTH Male Female SSN/TIN**

Natural Child/Stepchild Adopted/Legal Guardian Other (specify) Physically Handicapped Full-time Student Over 19

Section 5 – Ancillary Insurance Information (NOTE: Products are offered by US Able Life or other carriers which are independent and solely responsible. These are NOT BlueCross BlueShield products.)

ELECT (Mark all that apply): Basic Life/ADD Dependent Life STD LTD Supplemental Life/ADD Life Class Annual Salary \$.00

BASIC LIFE INSURANCE AMT \$.00 OR TIMES SALARY
 SUPPLEMENTAL LIFE/ADD AMT \$.00 OR TIMES SALARY

BENEFICIARY	RELATIONSHIP	PERCENTAGE	BENEFICIARY	RELATIONSHIP	PERCENTAGE
1			3		
2			4		

Section 6 – 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 Vision Basic Life/ADD Dependent Life STD LTD Supplemental Life/ADD

Reason for declining (Mark all that apply):

Other group medical coverage Other group dental coverage
 Other group vision 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 3 when electing any coverage)

DATE

Special Enrollment Period for Medical, Dental and Vision: 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 also may enroll at the next Open Enrollment Period.