Blount County Government
Human Resources
397 Court St
Maryville TN 37804

Medical and Dental MEMBER CHANGE FORM

Fax completed form to:

Blount County
Human Resources
Department
865-273-5783

PART A – INSURED INFORMATION (Complete for all changes.)

Last Name First Middle Initial			Social Security	
Street Address Apartment No.	City		State	Zip
Group Name	Department		Effective Date of Change	

PART B – CHANGE INFORMATION (Check [] appropriate change[s].)

	Change From			Change To		
o **Name**	Last Name First Middle Initial			Last Name First Middle Initial		
o **Address**	Street Address Apartment No.			Street Address Apartment No.		
	City	State	Zip	City	State	Zip
o **Phone**	Home: ( )			Home: ( )		
	Work: ( )			Work: ( )		

o **Addition of Dependent(s)** (Attach adoption papers, marriage or birth certificate, etc.)

Does dependent(s) have other coverage? Yes No

If yes, name of insurance carrier:

Last Name First Middle Initial	Social Security Number	Date of Birth	Sex	Relationship to Insured	Medical or Dental or Both	Reason for Addition (marriage, birth, adoption, etc.)

o **Removal of Dependent(s)** (State reason for removal, i.e., divorce, death, overage child, marriage of child, voluntary termination, etc. attach documents)

Last Name First Middle Initial	Social Security Number	Date of Birth	Sex	Relationship to Insured	Medical or Dental or Both	Reason for Removal

PART C – SIGNATURE (This form must be signed and dated before it can be processed.)

I hereby apply for amendment of my health plan application. It is mutually agreed that (1) these changes will not become effective unless and until this change form is signed and accepted, and (2) this application for change in coverage will become a part of my original health plan application and will be subject to the terms of the agreement in effect with my employer and/or TPA Services. If a change in health plan premium is required as a result of the changes requested herein, I agree to have my employer deduct the changed premium from my wage or salary. Monthly dependent premiums for medical $100.00 and for dependent dental $43.82 until further notice.

Authorized Signature	Date

USAble Life
P.O. Box 1650
Little Rock, Arkansas 72203

Group Enrollment or Change Form

(Please print or type in Black ink.)

☑ New Employee ☐ Declination ☐ Change of Name
☐ Beneficiary Change ☐ Class or Salary Change
☐ Dependent Status Change (Indicate reason _____)
☐ Reinstatement (Complete Date of Rehire as Employment Date)

Group # 10011711
Class 1
Dept/Location SCHOOLS
Eff Date _____

SECTION 1 - APPLICANT INFORMATION

Employee Name (First, M.I., Last)		For Name Change, Give Prior Last Name			
Social Security #	Date of Birth	Sex ☐ Male ☐ Female	Employee's State of Residence	Marital Status	
Occupation	Date Employed Full-time	Hours worked weekly	Salary $ _____ ☐ Weekly ☐ Monthly ☐ Annual		
Employer's Name: BLOUNT COUNTY SCHOOLS	Do you have eligible dependent children? ☐ Yes ☐ No	Are you actively at work on the date of this application? ☐ Yes ☐ No			

SECTION 2 - Complete this Section if applying for Optional Coverage(s). Evidence of Insurability (EOI) may be required when applying for these coverage(s).

	Add	Delete		Add	Delete
☐ Supp. Life/AD&D	☐	☐	☐ Dependent Life	☐	☐
☐ STD	☐	☐	Indicate Date of:		
☐	☐	☐	Marriage/Divorce		
☐	☐	☐	Birth of Child		
☐ LTD	☐	☐			

SECTION 3 -BENEFICIARY DESIGNATION /CHANGE ☐ Check if Change Only

This will revoke any existing beneficiary designations you may have for these benefits.

PRIMARY BENEFICIARY(IES) (Will receive proceeds if living at death of Employee):

Name (Last, First, MI)	Address	SSN	Birthdate	Relationship	Percentage

Total must equal 100% =

CONTINGENT BENEFICIARY(IES) (Will receive proceeds if Primary Beneficiary(ies) are not living):

Name (Last, First, MI)	Address	SSN	Birthdate	Relationship	Percentage

Total must equal 100% =

I represent that the information provided above is true and correct. I understand that if I am not actively at work on the effective date of my coverage, my insurance will not begin until the day I return to work. I hereby designate the above beneficiaries under this certificate and revoke the appointment of any existing beneficiary. If the Group Insurance Plan provides that any contributions be made by me, I authorize my employer to deduct them from my pay.

Warning: Any person who commits a fraudulent act may be guilty subject to fines and confinement in prison.

☐ Declination – I do not wish to enroll in the Group Plan at this time and I understand that I will have to furnish evidence of insurability at my own expense if I apply at a later date.

_____ Date

_____ Signature of Employee

FOR HOME OFFICE USE - IF COVERAGE SUBJECT TO EOI, UNDERWRITING DECISION		Date Received Home Office
APPROVED EFFECTIVE:	DECLINED DATE:	
BY:	BY:	

1000 (2-03)