KNOX COUNTY ESC
EMPLOYEE BENEFIT PLAN ENROLLMENT FORM
506-825A

PLEASE PRINT OR TYPE

Employee's Name____Soc.Sec.#______________________

Address____

Street City State Zip Code

Date of Birth______________Sex________________Home Phone Number ___________________Occupation_____________________

Are you applying for **Dental/Vision** coverage? (YES)______ (NO)______

If Yes, will coverage include your dependents? (YES)______ (NO)______

If coverage includes dependents, you *must* list and attach proof of marriage, birth, etc. Give last name of dependent if other than yours.

Name of Spouse_______________________Date of Marriage________________SS#__________________ DOB____________

Name of Dep___________________________Sex_______ Rel________________ SS#___________________DOB____________

Name of Dep___________________________Sex_______ Rel________________ SS#___________________DOB____________

Name of Dep___________________________Sex_______ Rel________________ SS#___________________DOB____________

Name of Dep___________________________Sex_______ Rel________________ SS#___________________DOB____________

Do ALL covered dependents live at the same address as above? (YES) _____ (NO)_____

If NO, please provide dependent name and address: ____

If child(ren) is age 19 - 25 and a full-time student, give name of school:____________________________________

____

Is your spouse Employed? (YES)______ (NO)______ If YES, where?____

Do you, your spouse or dependents have other dental/vision coverage (through Medicare or another plan)? (YES)______ (NO)______

If YES, list insurance company, type of coverage and individual covered_______________________________________

I request insurance under my Employer's Group Benefit Plan. I am actively at work the minimum number of hours required to participate in the plan.

I REQUEST COVERAGE UNDER MY EMPLOYER'S BENEFIT PLAN I AM ACTIVELY AT WORK THE MINIMUM NUMBER OF HOURS REQUIRED TO PARTICIPATE IN THE PLAN. I HEREBY CERTIFY THAT THE ABOVE STATEMENTS ARE ACCURATE. I AUTHORIZE ANY PERSON OR INSTITUTION RENDERING CARE, OR ANY PERSON OR ORGANIZATION (INCLUDING MY EMPLOYER) IN POSSESSION OF INFORMATION CONCERNING INSURANCE OR OTHER BENEFITS COVERING ME OR MY DEPENDENTS, TO FURNISH TO, OR RECEIVE FROM SELF-FUNDED PLANS, INC OR ITS AUTHORIZED REPRESENTATIVE, FULL INFORMATION REGARDING SUCH CARE OR OTHER BENEFIT INFORMATION. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL. THIS AUTHORIZATION SHALL REMAIN IN EFFECT FOR AS LONG AS MY DEPENDENTS AND I ARE ELIGIBLE TO RECEIVE BENEFITS UNDER THE PLAN

PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY MISREPRESENTATION OR ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW AND MAY BE SUBJECT TO CIVIL PENALTIES.

****

Signature of Employee____Date Signed____________________

****

TO BE COMPLETED BY EMPLOYER

Date of full-time Employment__________________

Date Enrollment form was received by Employer:_______________

Check if applicable:

_____Special Enrollee due to:

1. ____ **Dependent Event:**___marriage/ ____birth/ ____adoption/placement for adoption Date of Dependent Event__________
2. ____ **Loss of Coverage: Attach proof of loss of coverage and written waiver of coverage form**

FOR COMPANY USE ONLY

DENTAL/VISION_____ Effective Date _________________

6/12.18