RETIREE
2022 BLOUNT COUNTY
ENROLLMENT FORM MEDICAL, DENTAL, VISION

RT-001

(Please complete the entire form)

Please return the signed and completed form to Human Resources via mail, fax to 865-273-5783, or email to hr@blounttn.org.
You will receive information/letter from Allegiance to make arrangements to pay monthly premiums.

EMPLOYEE INFORMATION: 1.) Effective Date of Retirement: ________________________

Last Name / Legal Given First Name / MI			Social Security Number:
Home Mailing Address			Retired from which department or school:
City	ST	Zip	☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Home Telephone: ( )	Cell Telephone: ( )		E-mail Address:

OTHER INSURANCE AVAILABILITY INFORMATION:

Do you or any of your dependents have other medical coverage in addition to this health plan? ☐ No ☐ Yes If yes please provide the following:

Name(s) of Those Covered: ____

Insurer/Carrier________________________Effective Date of Other Coverage ______________

Term Date of Other Coverage ______________

Type of coverage: ☐ Single ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family Policy/Group

Number____________________Member ID Number ____________________

Do you or any of your dependents have other dental coverage in addition to this dental plan? ☐ No ☐ Yes If yes please provide the following:

Name(s) of Those Covered: ____

Insurer/Carrier________________________Effective Date of Other Coverage ______________

Term Date of Other Coverage ______________

Type of coverage: ☐ Single ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family Policy/Group

Number____________________Member ID Number ____________________

COORDINATION WITH MEDICARE: Important Information

Medicare Part A and Part B will be considered a plan for the purposes of coordination of benefits. This Plan will coordinate benefits with Medicare whether or not the Covered Person is actually receiving Medicare Benefits. This means that this Plan will only pay the amount that Medicare would not have covered, even if the Covered Person does not elect to be covered under Medicare. Also, failure to enroll in Medicare Part B when a person is initially eligible may result in the person being assessed a significant surcharge by Medicare for late enrollment in Part B.

For Covered Persons who are Disabled

This Plan is secondary and Medicare will be primary for the covered Employee or any covered Dependent who is eligible for Medicare by reason of disability if the Employee is retired or otherwise not actively working for the Employer.

For Covered Persons with End Stage Renal Disease

Except as stated below*, for Employees or Retirees and their Dependents, if Medicare eligibility is due solely to End Stage Renal Disease (ESRD), this Plan will be primary only during the first thirty (30) months of Medicare coverage. Thereafter, this Plan will be secondary with respect to Medicare coverage, unless after the thirty-month period described above, the Covered Person has no dialysis for a period of twelve (12) consecutive months and:

A. Then resumes dialysis, at which time this Plan will again become primary for a period of thirty (30) months; or

B. The Covered Person undergoes a kidney transplant, at which time this Plan will again become primary for a period of thirty (30) months.

*If a Covered Person is covered by Medicare as a result of disability, and Medicare is primary for that reason on the date the Covered Person becomes eligible for Medicare as a result of End Stage Renal Disease, Medicare will continue to be primary and this Plan will be secondary.

AUTHORIZATION / SWORN STATEMENT:

I certify that I have read and understand the above Coordination with Medicare statement. THIS FORM MUST BE SIGNED AND DATED BY THE EMPLOYEE BEFORE IT CAN BE PROCESSED.

Employee signature ______________________________ Date ________________

Insurance will automatically term on your 65th birthday, as long as you pay the monthly premiums required.
If you cover your spouse they will automatically term on their 65th birthday and children can be covered up to age 26.

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Enrollment Elections Authorization / Sworn Statement

COVERAGE TYPE: Indicate which level of coverage you are electing for your RETIREE Medical, Dental, and Vision coverage through BCG below. You must list all family members in the section below or you risk errors in your enrollment. If you wish to waive someone from your coverage, list their name and circle "W" for WAIVE.

Allegiance (a Cigna company)
Medical Monthly Premiums

Gold Plan	Silver Plan	Bronze Plan
⌡ Employee: $158.00	⌡ Employee: $101.00	⌡ Employee: $64.00
⌡ Employee + Spouse: $362.00	⌡ Employee + Spouse: $232.00	⌡ Employee + Spouse: $148.00
⌡ Employee + Child(ren): $355.00	⌡ Employee + Child(ren): $228.00	⌡ Employee + Child(ren): $145.00
⌡ Family: $367.00	⌡ Family: $235.00	⌡ Family: $151.00
⌡ *Waive MEDICAL*	⌡ *Waive MEDICAL*	⌡ *Waive MEDICAL*

Delta Dental Monthly Premiums	Superior Vision Monthly Premiums
	⌡ Employee: $8.88
Employee: $5.25	⌡ Employee + Spouse: $17.53
Employee + Family: $64.85	⌡ Employee + Child(ren): $17.18
Waive DENTAL	⌡ Employee + Family: $26.15
	⌡ *Waive VISION*

Indicate the coverage requested for the plan year for each individual listed by circling the appropriate letter in each column:
K = Keep No Changes; A = Add to Plan; W = Waive (do not want coverage)

	Please list all family members LEGAL GIVEN NAME Last First Middle Initial	SOCIAL SECURITY NUMBER	SEX	BIRTH DATE	MEDICAL K= Keep A=Add W=Waive	DENTAL K=Keep A=Add W=Waive	VISION K=Keep A=Add W=Waive
Employee					K A W	K A W	K A W
Spouse					K A W	K A W	K A W
Child					K A W	K A W	K A W
Child					K A W	K A W	K A W
Child					K A W	K A W	K A W
Child					K A W	K A W	K A W
Child					K A W	K A W	K A W
Child					K A W	K A W	K A W

AUTHORIZATION / SWORN STATEMENT:

I certify that the answers provided on this form are true and correct. A person may be committing insurance fraud if he or she submits this form containing a false or deceptive statement with the intent to defraud (or knowing that he or she is helping to defraud).

THIS FORM MUST BE SIGNED AND DATED BY THE EMPLOYEE BEFORE IT CAN BE PROCESSED.

Employee signature____ Date ______________________

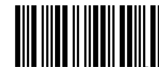
WAIVER: Complete this section ONLY if you do NOT want medical or dental coverage for yourself, spouse, and/or dependents.

Who is declining medical coverage? (Check any that may apply.) ☐ Self ☐ Spouse ☐ Dependent(s)
Who is declining dental coverage? (Check any that may apply.) ☐ Self ☐ Spouse ☐ Dependent(s)

WAIVER AUTHORIZATION: I certify that I, my spouse, and/or dependent(s) as indicated above are not to be covered under the health insurance offered by my employer. I understand that persons declining coverage now may be able to apply for coverage in the future and may be required to show evidence of exhaustion of benefits, loss of eligibility for coverage, termination of employer contributions and/or termination of prior benefits. I may be required to furnish such evidence at my expense. I also understand that those declining coverage now but later seeking coverage must enroll within a specific timeframe (e.g., 31 days after termination of the prior group benefits) and that additional limitations and waiting periods may apply.

Employee signature____ Date ______________________

Retiree-
County Life Beneficiary Designation



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Retiree County Provided Life Insurance in the amount of $10,000 up to midnight before 65th birthday.
AD&D pays an additional percentage of the amount of your life insurance benefit based on a specific list of losses.

Effective Date: __________________________

Employee Legal Give name
(Please print)____

Employee/Retiree social security number_____________________________________

Primary beneficiary designation

First and last name____Relationship___________________________

Address of beneficiary____

City____State___________ZIP code____________________Percentage_____________

First and last name____Relationship___________________________

Address of beneficiary____

City____State___________ZIP code____________________Percentage_____________

Secondary beneficiary designation (optional)

First and last name____Relationship___________________________

Address of beneficiary____

City____State___________ZIP code____________________Percentage_____________

First and last name____Relationship___________________________

Address of beneficiary____

City____State___________ZIP code____________________Percentage_____________

Employee signature____Date signed ___________________

If two or more primary beneficiaries are named, and you do not list the benefit percentages, proceeds will be paid in equal shares to the named primary beneficiaries who survive you. If no primary beneficiary survives you, proceeds will be paid to the contingent beneficiaries. If no designated beneficiary survives you, the beneficiary will be determined according to the provisions of the group life insurance contract.