Blount County Government
Retiree Benefits Enrollment

Complete entire form to enroll in Medical, Dental, or Vision
Return the completed and signed form to Human Resources via interoffice mail, fax to 865-273-5783, or email to hr@blounttn.org
After processed, you will receive information/letter from Allegiance to make payment arrangements to pay monthly premiums.

Effective Date of Retirement _____

Last Name	Legal Given First Name	MI	Last 4 Digits of Social Security Number

Current Mailing Address	Work Location Prior to Retirement

City	ST	Zip Code	☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Home Phone	Cell Phone	E-mail Address
( )	( )	

OTHER INSURANCE COVERAGE 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

Police/Group Number _____ Member ID Number _____

Do you or any of your dependents have other DENTAL 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

Police/Group Number _____ Member ID Number _____

IMPORTANT INFORMATION: COORDINATION WITH MEDICARE

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 (30) 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 STATMENT

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 _____

Enrollment Elections Authorization / Sworn Statement

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 child(ren) are eligible for coverage up to age 26.

COVERAGE TYPE

Indicate which level of coverage you are electing for your RETIREE Medical, Dental, and Vision coverage through Blount County Government 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

GOLD PLAN MONTHLY PREMIUMS		SILVER PLAN MONTHLY PREMIUMS		BRONZE PLAN MONTHLY PREMIUMS	
☐ Employee	$ 163.00	☐ Employee	$ 104.00	☐ Employee	$ 66.00
☐ Employee + Spouse	$ 373.00	☐ Employee + Spouse	$ 239.00	☐ Employee + Spouse	$ 152.00
☐ Employee + Child(ren)	$ 366.00	☐ Employee + Child(ren)	$ 235.00	☐ Employee + Child(ren)	$ 149.00
☐ Family	$ 378.00	☐ Family	$ 242.00	☐ Family	$ 156.00

☐ Waive Medical

DENTAL VISION MONTHLY PREMIUMS		SUPERIOR VISION MONTHLY PREMIUMS	
☐ Employee	$ 5.50	☐ Employee	$ 8.54
☐ Employee + Family	$ 67.48	☐ Employee + Spouse	$ 16.86
		☐ Employee + Child(ren)	$ 16.52
☐ Waive DENTAL		☐ Family	$ 25.14
		☐ Waive VISION	

Indicate the coverage requested for the plan year for each individual listed by circling the appropriate letter in each column below:
A= Add to Plan W= Waive (Do not want coverage)

Please list all family members. LEGAL GIVEN NAME — LAST / FIRST / MI	SOCIAL SECURITY NUMBER	SEX	BIRTH DATE	MEDICAL Add or Waive	DENTAL Add or Waive	VISION Add or Waive
EMPLOYEE				A W	A W	A W
SPOUSE				A W	A W	A W
CHILD				A W	A W	A W
CHILD				A W	A W	A W
CHILD				A W	A W	A W
CHILD				A W	A W	A W
CHILD				A W	A W	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 _____