of Tennessee

1 Cameron Hill Circle
Chattanooga, TN 37402-0001
bcbst.com

- CONFIDENTIAL -

ADD DEPENDENT / CHANGE REQUEST

PLEASE USE BLUE OR BLACK INK ONLY

Plan Use Only
Rec:_____

ADC-15

Section 1 – Select Type of Change - Please mark all that apply

IDENTIFICATION NO. | EMPLOYEE LAST NAME | EMPLOYEE FIRST NAME | MI | GROUP NO. | GROUP NAME

❑ Add/Change Dependent(s) ❑ Add/Change Medical Coverage ❑ Add/Change Dental Coverage ❑ Add/Change Vision Coverage ❑ Add/Change Life Coverage ❑ Add/Change Health Care FSA

❑ Add/Change Dependent Care FSA ❑ Change Name/Date of Birth ❑ Change Address/Phone No./Email ❑ Change Subgroup/Department ❑ Change Salary ❑ Change Life Beneficiary

Event Date __/__/____

Reason for change: ❑ Loss of Other Medical Coverage ❑ Loss of Other Dental Coverage ❑ Loss of Other Vision Coverage ❑ Continuation Coverage Period Expired ❑ Marriage ❑ New Dependent Child ❑ Open Enrollment ❑ Court Order ❑ Other (FSA Only)

Section 2 - Currently Enrolled Employee - You only need to fill in the sections you want to change

STREET ADDRESS: **PHONE:** ___-___-____

CITY (PLEASE DO NOT ABBREVIATE) STATE ZIP **DATE OF BIRTH:** __/__/____ ❑ **SPANISH IS MY PRIMARY HOUSEHOLD LANGUAGE**

EMAIL ADDRESS*:**

NAME: LAST NAME: FIRST NAME: MI: JR., SR., ETC: REASON FOR NAME CHANGE:

MEDICAL OPTION: ❑ 1 ❑ 2 ❑ 3 ❑ 4 Other ❑ Ind ❑ Fam ❑ EE/Spouse ❑ EE/Child(ren) **Effective Date:** __/__/____

DENTAL OPTION: ❑ 1 ❑ 2 ❑ 3 ❑ 4 Other ❑ Ind ❑ Fam ❑ EE/Spouse ❑ EE/Child(ren) **Effective Date:** __/__/____

VISION OPTION: ❑ 1 ❑ 2 ❑ 3 ❑ 4 Other ❑ Ind ❑ Fam ❑ EE/Spouse ❑ EE/Child(ren) **Effective Date:** __/__/____

FSA OPTION: ❑ Health Care: $ ____.__ Annual Pledge Amount*

If your Group does not offer a debit card with FSA, should BCBST automatically pay Health Care FSA funds when medical claims are processed? ❑ **YES** ❑ **NO**

Effective Date: __/__/____

❑ Dependent Care: $ ____.__ Annual Pledge Amount*

Effective Date: __/__/____

Other changes: Subgroup No. Dept. No. **Effective Date:** __/__/____

Section 3 – Acknowledgement - Signature and Date MUST BE COMPLETED

If you or listed dependents will be covered by other health, dental or Medicare insurance when this plan goes into effect, indicate which coverage. ❑ **Medical/Medicare** ❑ **Dental** HICN

I understand, and agree, that I am applying for coverage and: 1) that any contract which may be issued to me will be subject to all the terms and conditions of the Group Agreement; 2) that my signature on this form will authorize any doctor, hospital, or other provider of treatment to furnish BlueCross BlueShield of Tennessee any and all medical records pertaining to any person covered by the contract and that; 3) I am responsible for any fee for these records; 4) that Health and Dependent Care Flexible Spending Accounts (FSAs) are on a pre-tax basis and they cannot be changed prior to the end of the plan year unless a change in status event occurs as defined in the Summary Plan Description and I will forfeit any amount remaining in the account after all eligible expenses are submitted for reimbursement should I over estimate my annual needs.

Employee's Signature: X Date: __/__/____

**Annual maximum applies. See your Benefits Administrator if you have questions.* ***To comply with Federal regulations we must have SSN/TIN.* ****By providing your email address, you are agreeing to receive all communications (presently available or that become available during the term of your policy) related to this policy, the benefits considered under this policy, your relationship with BCBST, etc., in electronic form from BCBST or its subsidiaries.*

A scanned, imaged or photocopied version of this completely executed form will have the same force and effect as the original document.

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GROUP NO. EMPLOYEE LAST NAME EMPLOYEE FIRST NAME **ADC-15**

Section 4 – Dependent Adds / Changes (Additional dependents on back). Consult employer guidelines for dependent eligibility.

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

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

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

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 – Life Insurance Information - Life Insurance and related products are underwritten by independent life insurance carriers. If Beneficiary Percentage is left blank, benefits will be divided equally among beneficiaries.

DROP (Mark all that apply)

❑ Dependent Life ❑ STD ❑ LTD

ADD/CHANGE (Mark all that apply)

Change Life Class to: ❑ Basic Life/ADD ❑ Dependent Life ❑ STD ❑ LTD ❑ Supplemental Life

CHANGE EFFECTIVE: / /

EVENT DATE: / /

REASON: ❑ Marriage ❑ New Dependent Child

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		

Signature of Witness:

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)

X

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 may also enroll at the next Open Enrollment Period.