TICUA
BENEFIT CONSORTIUM

Enrollment Form

Complete when first eligible (newly hired) or at open enrollment if changing coverage

Section I: Employee Information

Employees, please fill out this page and return to your human resources department.

Last Name	First Name	MI	Social Security No.	Date of Birth	Gender
			- -	/ /	☐ M ☐ F

Home Address	City	State	Zip	Phone Number
				( )

Email

Marital Status	Enrollment Type	Coverage Level Selection	Benefit Plan Option
☐ Single	☐ New Enrollee	☐ Employee	☐ $400 Deductible
☐ Married	☐ Rehire	☐ Employee + One	☐ $1,000 Deductible
☐ Divorced	☐ Reinstatement of Coverage	☒ Family	☐ Waive Coverage
☒ Widowed	☐ Special Enrollment		
	☒ Open Enrollment		

Benefit Plan Option
☐ Qualified High Deductible
☒ Office Visit Co-Pay

Waiving Coverage Under the Plan –I Understand that by choosing not to be covered under this Plan I may affect my ability to be covered at a later date. I will only be able to add coverage at open enrollment or as a Special Enrollee as described on the reverse.

Section II. Dependent Information

Please list all dependents that you want covered under the TICUA Benefit Consortium Health Care Plan. **Dependents include spouse and children.** Enrollment or change form must be completed for all dependents within 31 days of their becoming eligible for coverage. Attach TBC Additional Dependents form where needed.

Name	Gender	Birthdate	SSN	Relationship (Spouse, son, daughter, etc.)	If Dependent was covered under a prior plan, list **original effective date of coverage.**
Last Name, First Name M.I.	Male			Spouse	
Last Name, First Name M.I.	Female				
Last Name, First Name M.I.	Female				
Last Name, First Name M.I.	Female				
Last Name, First Name M.I.	Female				
Last Name, First Name M.I.	Female				

Section III. Other Medical Coverage

If anyone you are enrolling has other medical coverage, please complete this section.

Name of Primary Insured			SSN of Primary Insured			Date of Birth
Last Name	First Name	M.I.				

Name of Employer	Employer Phone #	Circle Coverage Type
	( )	☐ Single Family ☐

Name of Insurance Carrier →

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Section IV. Other Natural Parent Information If you are **divorced** and have a child, please enter other natural parent's information.

If you are divorced, does your child live with his or her other natural parent? →	☐ Yes ☐ No
If child does not live with you or other natural parent, please specify other living arrangement: →	

Last Name	First Name	MI	Social Security No.	Date of Birth
				/ /

Home Address	City	State	Zip	Phone Number
				( )

Place of Employment	Employer Address	Employer Phone No.
		( )

Please provide the following to the human resources department at your institution

1. A copy of that portion of your divorce decree that mandates which party is to provide coverage for medical care for this dependent.
2. If this issue is ***not*** specified in your divorce decree, you ***must*** provide either (1) A copy of the legal assignment of Medical Care provided by a court **OR (**2) A notarized statement that you are principally responsible for the medical care of this dependent child.

I certify that the above is a complete statement of other medical care/coverage available for the above dependent.

Signature of Employee: (Divorced Parent Signature Only)

EMPLOYEE, PLEASE READ AND SIGN BELOW

SPECIAL ENROLLMENT: If an eligible Employee or Dependent declined health coverage hereunder at the time of initial eligibility (and stated in writing at the time that coverage was declined because of alternative health coverage) but subsequently loses coverage under the other health plan and makes application for coverage hereunder within 31 days of the loss, such individual shall be a Special Enrollee provided such person: (a) was under a COBRA continuation provision and the coverage under such provision was exhausted; or (b) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contribution toward such coverage were terminated. Individuals who lose other coverage due to nonpayment of premium, for cause (e.g., filing fraudulent claims) shall not be Special Enrollees hereunder. An eligible Employee or Dependent who seeks to enroll in the Plan as a result of the acquisition of a new Dependent through marriage, birth, adoption or placement for adoption shall be a Special Enrollee hereunder if the eligible Employee or Dependent enrolls within 31 days of the acquisition of the new Dependent. Coverage for a Special Enrollee (other than a newborn or newly adopted child) shall begin as of the date of the change. Coverage for a newly adopted or newborn Special Enrollee shall begin as of the day of the adoption, birth, or placement for adoption.

I hereby authorize any Hospital, Physician, Organization, Employer, Insurance Company or Administrator to release any information pertinent to my claims while covered under this Plan.

I hereby request all coverage indicated above for which I am or may become eligible under the TICUA Benefit Consortium, Inc. Health Plan. I authorize my employer to deduct from my earnings any contributions required of me for the payment of premiums for such coverage.

Employee's Signature		Date Signed	

Section II: TO BE COMPLETED BY HUMAN RESOURCES ONLY

Employer, fill out this page and mail or fax both pages of the Enrollment Form to TICUA Benefit Consortium, 1031 17th Avenue South, Nashville, TN 37212, Fax (615) 292-3933.

College/University Name	Group No.	Employee Hire Date	Coverage Effective Date

Received Certificate of Creditable Coverage? →	Yes No	If **Yes**, then fax or mail the Certificate of Creditable Coverage along with this Enrollment form.

Employer Certification: I certify that all the information included on this form is current and correct to the best of my knowledge.

Employer Signature		Date Signed	

Employer Notes:

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