Johnson City Schools
Health/Dental Enrollment/Change Form

__New Hire __Open Enrollment __Divorce/Legal Separation __Court Order
__Dependent Child No Longer Eligible __Employee Eligible for Medicare
__Drop Dependent
__Qualifying Event-Explanation____

Employee Name (Last, First, Middle Initial): ______________________________

Social Security Number:______________________ Date of Birth: ______________
__Male __Female

Address:____

Phone: ____

Plan Selection: __A (Preferred) __B (Select)

Coverage Type: __Employee Only __Employee +1 __Family

See pages 60 and 66 in the Evidence of Coverage Booklet for copay and deductible details. The Blue Cross Blue Shield Evidence of Coverage Book is located on our website at www.jcschools.org then employees and insurance.

Employee should notify Johnson City Schools if any dependent's address is different from the employee's address. It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of coverage. 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 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; See your Benefits Administrator if you have questions.

Employee's Signature:_______________________________ Date:_______________

If selecting Employee + 1 or Family Coverage, please complete your dependent(s) information on the back of this form.

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

If you are adding a spouse, please include a copy of your marriage certificate. If you are adding dependent children, please include a copy of their birth certificate.

If selecting Employee + 1 or Family Coverage, please complete your dependent(s) information:

Spouse Name (Last, First, Middle Initial):____

Social Security Number:____________________ Date of Birth: _______________________
__Male __Female

Dependent Name (Last, First, Middle Initial):____

Social Security Number:____________________ Date of Birth: _______________________
__Male __Female __Natural Child/Stepchild __Adopted/Legal Guardian __Other__________

Dependent Name (Last, First, Middle Initial):____

Social Security Number:____________________ Date of Birth: _______________________
__Male __Female __Natural Child/Stepchild __Adopted/Legal Guardian __Other__________

Dependent Name (Last, First, Middle Initial):____

Social Security Number:____________________ Date of Birth: _______________________
__Male __Female __Natural Child/Stepchild __Adopted/Legal Guardian __Other__________

Dependent Name (Last, First, Middle Initial):____

Social Security Number:____________________ Date of Birth: _______________________
__Male __Female __Natural Child/Stepchild __Adopted/Legal Guardian __Other__________

Dependent Name (Last, First, Middle Initial):____

Social Security Number:____________________ Date of Birth: _______________________
__Male __Female __Natural Child/Stepchild __Adopted/Legal Guardian __Other__________

Dependent Name (Last, First, Middle Initial):____

Social Security Number:____________________ Date of Birth: _______________________
__Male __Female __Natural Child/Stepchild __Adopted/Legal Guardian __Other__________

Dependent Name (Last, First, Middle Initial):____

Social Security Number:____________________ Date of Birth: _______________________
__Male __Female __Natural Child/Stepchild __Adopted/Legal Guardian __Other__________