KNOX COLLEGE
GROUP ENROLLMENT FORM / CHANGE FORM

☐ NEW ENROLLEE ☐ CHANGE IN CURRENT STATUS ☐ OPEN ENROLLMENT EFFECTIVE DATE: _____

YOUR NAME (Please Print) _____

ADDRESS _____

Street/Apt #

_____

City State Zip

Phone: Home Work

☐ MALE ☐ FEMALE
GENDER

____/____/____
MONTH/DAY/YEAR
DATE OF BIRTH

_____
SOCIAL SECURITY NUMBER

☐ SINGLE
☐ MARRIED
DATE OF MARRIAGE: ____/ ____/ _____
☐ DOMESTIC PARTNER

COVERAGE (Check only those that apply)

MEDICAL COVERAGE:	☐ EMPLOYEE ONLY	☐ EMP + CHILD(REN)	☐ EMP + SPOUSE	☐ FAMILY	MEDICAL PLAN: ☐ PPO ☐ HDHP
DENTAL/VISION COVERAGE:	☐ EMPLOYEE ONLY	☐ EMP + CHILD(REN)	☐ EMP + SPOUSE	☐ FAMILY	

DEPENDENT INFORMATION (Complete if you are covering any dependents)

DEPENDENT	M	F	FIRST	MIDDLE INT.	LAST	SSN#	DATE OF BIRTH MONTH/DAY/YEAR
SPOUSE	☐	☐					
CHILD	☐	☐					
CHILD	☐	☐					
CHILD	☐	☐					

IF YOUR SPOUSE OR CHILDREN HAVE A LAST NAME DIFFERENT FROM YOURS, PLEASE PROVIDE A MARRIAGE LICENSE AND/OR BIRTH CERTIFICATE.
IF YOUR DEPENDENT CHILD IS 26 OR OLDER, PLEASE PROVIDE DISABILITY VERIFICATION.

OTHER INSURANCE

ARE YOU OR ANY OF YOUR DEPENDENTS COVERED BY ANOTHER GROUP MEDICAL, DENTAL OR VISION PLAN? ☐ YES ☐ NO

IF YES, EFFECTIVE DATE OF COVERAGE _____ / _____ / _____ TYPE OF COVERAGE: ☐ MEDICAL ☐ DENTAL ☐ VISION

NAME OF PRIMARY INSURED / POLICY HOLDER _____ DATE OF BIRTH OF POLICY HOLDER_____/ _____/ _____

NAME OF COVERED DEPENDENT(S) _____

ID NUMBER _____ NAME OF INSURANCE CARRIER OR TPA _____

ADDRESS_____ PHONE _____

NAME OF OTHER EMPLOYER PROVIDING COVERAGE _____ IS MEDICARE/MEDICAID APPLICABLE? ☐ YES ☐ NO

IS YOUR SPOUSE EMPLOYED? ☐ YES ☐ NO IF YES, IS SPOUSE ELIGIBLE FOR INSURANCE THROUGH EMPLOYER NOW OR IN THE FUTURE? ☐ YES ☐ NO

PROVIDE DETAILS_____

IS THERE A DIVORCE DECREE OR COURT ORDER REQUIRING YOU TO BE FINANCIALLY RESPONSIBLE FOR MEDICAL COVERAGE FOR DEPENDENT CHILDREN? ☐ YES ☐ NO
IF YES, PROVIDE COPY WHO HAS PRIMARY CUSTODY OF COVERED CHILDREN? ☐ MOTHER ☐ FATHER

BENEFIT WAIVER STATEMENT

I THE UNDERSIGNED CERTIFY THAT I HAVE BEEN GIVEN AN OPPORTUNITY TO APPLY FOR THE GROUP BENEFIT PLAN OFFERED BY THE COMPANY AND AFTER CAREFUL CONSIDERATION HAVE DECIDED TO DECLINE TO ENROLL IN THE COVERAGE HEREAFTER INDICATED.

DECLINE ☐ MEDICAL ☐ DENTAL/VISION
ARE YOU DECLINING DUE TO COVERAGE IN ANOTHER PLAN? ☐ YES ☐ NO {IF BLANK, THE PLAN WILL ASSUME "NO")
IF YES, IS THIS OTHER COVERAGE COBRA? ☐ YES ☐ NO

☐ OTHER [PLEASE EXPLAIN) _____

IMPORTANT NOTICE: If you refuse coverage for yourself, you automatically refuse coverage for any dependents. If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan. Provided that you request enrollment within 30 days after your other coverage ends. Also, you must indicate the reason for declining enrollment to later be eligible under the special enrollment rules. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provide that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption I have received and read a summary of foe plan description, and any amendments regarding the impact of HIPAA. I certify that the above information is hue and accurate.

SIGNATURE OF EMPLOYEE to DECLINE_____ DATE SIGNED_____

DATE AND SIGN ENROLLMENT FORM ELECTIONS

SIGNATURE OF EMPLOYEE to ENROLL _____ DATE SIGNED_____

If contributions are required for any of the above coverage, I authorize the Company to deduct from my earnings the applicable tax sheltered contribution(s) for the coverage hereafter listed (if none, please indicate.)