Holston Conference UMC Health Insurance

2020 CHANGE REQUEST Form

Employee Data (*please print*)

Employee Name (Last, First, M.I.) ______________________ Employee Blue Cross Blue Shield 9-Digit ID Number ______________________

Reason for Change

☐ ***Open Enrollment***

☐ Loss of Other Medical Coverage ☐ Loss of Other Dental Coverage ☐ Loss of Other Vision Coverage

☐ Continuation Coverage Period Expired ☐ Marriage ☐ New Dependent Child ☐ Court Order

Type of Change/Event Date: / /

☐ Add/Change Dependent(s) ☐ Add/Change Medical Coverage ☐ Add/Change Dental Coverage

☐ Add/Change Vision Coverage ☐ Add/Change Health Care FSA ☐ Add/Change Dependent Care FSA

☐ Change Name/Date of Birth ☐ Change Address/Phone No./Email ☐ Change Church/Organization

Employee Name and Address Changes: (*Only Complete Areas You Need to Change in Name/Address section)*

New Address (Street, City, State, Zip) ______________________

New Phone Number ______________________ New E-mail Address ______________________

New Name (Last, First, M.I.) ______________________ New Church/Organization ______________________

Select Health Plan Options

Choose Level of Coverage: ☐ Individual ☐ E+1 ☐ Family

Choose Network (Tennessee Providers Only): ☐ Network "S" ☐ Network "P"

Choose Your Plan: ☐ PPO ☐ HSA Account with: ☐ Health Equity Acct. ☐ HFMCU Acct #: ______________

Enroll in Dental Plan *at No Additional Charge*? ☐ Yes ☐ No

Enroll in Vision Plan *with Additional Premium*? ☐ Individual ($11/mo) ☐ E+1 ($18/mo) ☐ Family ($27/mo)

Enroll in Flexible Spending Account? ☐ Yes ***(Must complete Progressive Benefit Solutions form)***

Medical Reimbursement Account Annual Amount: $______________

Dependent Care Reimbursement Account Annual Amount: $______________

Dependent Information: *(Additional dependents on separate sheet)*

Add / Remove Name Last, First, M.I., *Print please*) | Date of Birth | Social Security # | Sex | Vision

☐ ☐ ______________________ | ______________ | ______________ | ☐M ☐F | ☐Y ☐N

☐ Spouse ☐ Natural Child/Stepchild ☐ Adopted/Legal Guardian ☐ Other ______________ ☐ Physically Handicapped

Add / Remove Name Last, First, M.I., *Print please*) | Date of Birth | Social Security # | Sex | Vision

☐ ☐ ______________________ | ______________ | ______________ | ☐M ☐F | ☐Y ☐N

☐ Spouse ☐ Natural Child/Stepchild ☐ Adopted/Legal Guardian ☐ Other ______________ ☐ Physically Handicapped

Add / Remove Name Last, First, M.I., *Print please*) | Date of Birth | Social Security # | Sex | Vision

☐ ☐ ______________________ | ______________ | ______________ | ☐M ☐F | ☐Y ☐N

☐ Spouse ☐ Natural Child/Stepchild ☐ Adopted/Legal Guardian ☐ Other ______________ ☐ Physically Handicapped

Have your spouse/dependents had continuous health care for the past 12 months? ☐ Yes ☐ No

If no, what are the dates of most recent coverage? From ________________ to ________________

Acknowledgement

*I understand and agree that I am applying for coverage in the **Holston Conference Self-Insured Health Plan** administered by Blue Cross/Blue Shield of Tennessee and that my signature on this form will authorize any doctor, hospital, or other provider of treatment to furnish Blue Cross/Blue Shield of Tennessee any and all medical records pertaining to any person covered by this contract.*

Employee Signature: ______________________ Date Signed: ______________________

Questions? email: *openenrollment@holston.org* or visit *www.holston.org/openenrollment*

Please send completed form(s) to the Holston Conference Benefits Office before November 15, 2019,

by emailing them to ***openenrollment@holston.org***

or mailing them to **Holston Annual Conference, Attn: Open Enrollment, P.O. Box 850, Alcoa, TN, 37701**.