



2016 ANNUAL RETIREE BENEFITS ENROLLMENT FORM

(Please return to Employee Benefits by November 30, 2015)

A. RETIREE / PARTICIPANT INFORMATION

Social Security Number	Last Name	First Name	M.I.	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Home Street Address		Apt.	Effective Date	
City, State, Zip		Date of Birth	Contact No: () - <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	
Email Address				

B. MEDICAL PLAN – BlueCross BlueShield of Tennessee

IN ORDER TO BE ELIGIBLE FOR COVERAGE UNDER THE CITY OF KNOXVILLE'S RETIREE MEDICAL PLAN IN 2016, YOU MUST COMPLETE, SIGN, AND RETURN THE 2016 MEDICARE ELIGIBILITY AFFIDAVIT TO EMPLOYEE BENEFITS OFFICE!

You must decide if you and your covered dependents want to participate in the My Health option or the Medical Only option. Please mark your election and then select the Deductible, Network and desired level of coverage.

MY HEALTH OPTION

I and my covered dependents elect to participate in the **My Health option**.

To participate in the My Health option and receive the reduced premiums and incentives, you must certify the Nicotine status on the next page for yourself and your spouse (if you elect to cover your spouse for medical coverage).

<u>OPTION 1</u>	<u>OPTION 2</u>	<u>OPTION 3</u>	<u>OPTION 4</u>
\$500 deductible / Network S	\$500 deductible / Network P	\$1,000 deductible / Network S	\$1,000 deductible / Network P
I elect (monthly contribution):	I elect (monthly contribution):	I elect (monthly contribution):	I elect (monthly contribution):
<input type="checkbox"/> Retiree Only: \$322.44	<input type="checkbox"/> Retiree Only: \$351.46	<input type="checkbox"/> Retiree Only: \$298.55	<input type="checkbox"/> Retiree Only: \$325.43
<input type="checkbox"/> Retiree + Spouse: \$741.62	<input type="checkbox"/> Retiree + Spouse: \$808.35	<input type="checkbox"/> Retiree + Spouse: \$686.68	<input type="checkbox"/> Retiree + Spouse: \$748.47
<input type="checkbox"/> Retiree + Child(ren): \$590.06	<input type="checkbox"/> Retiree +Child(ren): \$643.17	<input type="checkbox"/> Retiree +Child(ren): \$546.34	<input type="checkbox"/> Retiree +Child(ren): \$595.53
<input type="checkbox"/> Retiree + Family: \$967.32	<input type="checkbox"/> Retiree + Family: \$1,054.38	<input type="checkbox"/> Retiree + Family: \$895.66	<input type="checkbox"/> Retiree + Family: \$976.27

Note: If your spouse is not covered under the City's medical plan today and you are enrolling your spouse for medical coverage for 2016, you may be required to pay a \$100 monthly surcharge in addition to the monthly contribution if he/she is eligible for coverage under another employer's plan.

MEDICAL ONLY OPTION

I and my covered dependents elect to participate in the **Medical Only option**.

<u>OPTION 1</u>	<u>OPTION 2</u>	<u>OPTION 3</u>	<u>OPTION 4</u>
\$500 deductible / Network S	\$500 deductible / Network P	\$1,000 deductible / Network S	\$1,000 deductible / Network P
I elect (monthly contribution):	I elect (monthly contribution):	I elect (monthly contribution):	I elect (monthly contribution):
<input type="checkbox"/> Retiree Only: \$348.96	<input type="checkbox"/> Retiree Only: \$380.37	<input type="checkbox"/> Retiree Only: \$323.11	<input type="checkbox"/> Retiree Only: \$352.19
<input type="checkbox"/> Retiree + Spouse: \$802.61	<input type="checkbox"/> Retiree + Spouse: \$874.84	<input type="checkbox"/> Retiree + Spouse: \$743.16	<input type="checkbox"/> Retiree + Spouse: \$810.04
<input type="checkbox"/> Retiree + Child(ren): \$638.60	<input type="checkbox"/> Retiree +Child(ren): \$696.07	<input type="checkbox"/> Retiree +Child(ren): \$591.29	<input type="checkbox"/> Retiree +Child(ren): \$644.51
<input type="checkbox"/> Retiree + Family: \$1,046.88	<input type="checkbox"/> Retiree + Family: \$1,141.10	<input type="checkbox"/> Retiree + Family: \$969.34	<input type="checkbox"/> Retiree + Family: \$1,056.57

Note: If your spouse is not covered under the City's medical plan today and you are enrolling your spouse for medical coverage for 2016, you may be required to pay a \$100 monthly surcharge in addition to the monthly contribution if he/she is eligible for coverage under another employer's plan.

If electing Medical coverage, you must complete the section below:

Do you or any of your covered dependents have other group health care coverage? Yes No
 If Yes, Name of Insured: _____
 Place of Employment: _____
 Insurance Company & Policy #: _____
 Insurance Company Address: _____

C. FAMILY MEMBERS TO BE COVERED - List all dependents to be covered. If you do not list a dependent, they will not be covered.

	Last Name	First Name	M.I.	Social Security Number	Date of Birth	Gender (M/F)	Check if covered	Month/year of most recent prior medical coverage
Spouse								From: To:
Child								From: To:
Child								From: To:
Child								From: To:

CERTIFICATION

Nicotine is defined as the use of any of the following within the past 60 days: cigarettes, cigars, e-cigs, pipes, chewing Nicotine, or any other Nicotine product.

By my designation, I certify **my** Nicotine use status. If I am a Nicotine User and I elected the My Health plan, I understand that I must participate in The Center's health coach program.

Non-Nicotine User Nicotine User

By my designation, I certify **my spouse's** Nicotine use status. If my spouse is a Nicotine User and I elected the My Health plan, he/she understands that they must participate in The Center's health coach program.

Non-Nicotine User Nicotine User

I certify that all information supplied on this form is true to the best of my knowledge and that I have read and understand the information entitled "Enrollment Information" provided below.

Participant Signature _____ Date _____

ENROLLMENT INFORMATION

Acceptance: By signing this form you are certifying that all information supplied on this form is true to the best of your knowledge. You understand that all benefits for yourself and your eligible dependents will be provided in accordance with the plan contract. You agree to abide by the terms and conditions governing membership and receipt of health services covered by the plans in which you have enrolled. You authorize your former employer to reduce your pension in an amount necessary to pay for your benefit elections. You understand that your pension reduction cannot be revoked or changed unless you change your election due to a life event as noted below. Your benefit change should be requested in writing within 60 days of the event. Additional paperwork may be required from you at that time. This signature is also to verify: (1) the accuracy of the information contained on this form; and (2) your decision to elect or decline participation in the City of Knoxville's benefit plans.

Special Late Enrollment Rights: In order for these rights to apply to you, you must state in writing that the reason you are currently declining coverage is because you are covered under other health insurance coverage. You may be able to enroll yourself and/or your dependents in this plan, provided that you request enrollment within 60 days after your other coverage ends. 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, provided that you request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.

Life Event: If you experience a life event, including but not limited to the list of life events below, you may be able to make certain changes to your benefits. Your benefit change must be consistent with the life event and be requested in writing within 60 days of the event. Additional paperwork may be required at that time.

- Change in retiree's legal marital status: Marriage, divorce, legal separation, death of spouse
- Change in number of dependents: Birth, adoption, placement for adoption, death of dependent
- Change in employment status of retiree or dependent: Termination, commencement of employment, coverage of dependent, loss or gain of benefit eligibility of dependent
- Dependent eligibility changes: Dependent is newly or no longer eligible (i.e., reached age 26)
- Material benefit change of retiree or dependent, including dependent's annual open enrollment
- Dependents gain or lose eligibility for Medicaid or SCHIP coverage.

Certificate of Creditable Coverage: The insurance company reserves the right to request from you a certificate of creditable coverage for any time period you are indicating you have had prior medical coverage.