KNOX COLLEGE
GROUP ENROLLMENT FORM / CHANGE FORM

☐ New Enrollee ☐ Change in Current Status *Effective date of change_____ Employment Date:_____

Your Name (Please Print) _____

Address _____
Street / Apt #

_____
City State Zip

Phone- Home _____

_____ Male ____ Female
GENDER

____ / ____ / _____
Mo. Day Year
DATE OF BIRTH

___ ___ ___ / ___ ___ / ___ ___ ___ ___
SOCIAL SECURITY NUMBER

☐ Single
☐ Married
☐ Domestic Partner

COVERAGE (Check only those that apply)

Medical Coverage:	☐ Single	☐ Emp + 1	☐ Family	Medical Plan:	☐ PPO
Dental/Vision Coverage:	☐ Single	☐ Emp + 1	☐ Family		☐ HDHP

DEPENDENT INFORMATION

DEPENDENT	M	F	FIRST	MIDDLE INITIAL	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. Date Of Marriage: ____ / ____ / ____

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 or dental plan? Yes_____ No_____

Is yes, effective date of coverage ____/____/____ Type of coverage: Medical_____ Dental _____
Name of primary insured/ policy holder: _____ Date of birth of policy holder _____/_____/_____
Name(s) of covered dependent(s): _____
Name of insurance carrier: _____
Name of other employer providing coverage: _____

Is your spouse employed? Yes_____ No _____
Is yes, if spouse eligible for insurance through employer now or in the future? Yes_____ No _____

Is there a divorce decree or court order requiring you to be financially responsible for medical coverage for dependent children? Yes _____ No _____

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 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 the plan description, and any amendments regarding the impact of HIPAA. I certify that the above information is true 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.)