HBAT
Home Builders Association
OF TENNESSEE
BENEFITS TRUST

Participant Enrollment/Change Form

Requested Effective Date of Coverage Change: __________

Step 1 Employer Information

Group Name/Group # ______________________________

Date of Hire ____________________

Position Title ____________________

Hours Worked per Week ____________________

Annual Income ____________________

Reason for Application:

- O New Group Plan
- O Life Event/Date ________
- O Status Change ________
- O Dependent Add/Delete
- O Change Name/Address
- O Waiving Coverage
- O Termination
- O New Hire
- O Annual Open Enrollment
- O Late Enrollee
- O Change in Coverage
- O Other ____________

Employee Type:

- O Active
- O COBRA
- O State Continuation
  - Start Date: / /
  - End Date: / /
- O Other ____________________
- O Hourly
- O Salary
- O Union
- O Non-Union
- O Retired

Step 2 Employee Information

Name ______________________________
Last *First* *MI*

Address ______________________________

City, State, Zip Code ______________________________

Email ______________________________

Birth date ____________ *mm/dd/yyyy*

Used tobacco in the last 12 months? O Y O N

Physician ______________________________
First & Last Name *Phone #*

Primary Care Dentist ______________________________
First & Last Name *Phone #*

Social Security # ____________________

Cell # ____________________

Work # ____________________

Sex O M O F

Height __________ Weight __________

Preferred Language ____________ *If not English*

Marital Status *Check correct status* O Single O Married O Divorced O Widowed

Step 3 Family Information

List all enrolling (attach sheet if necessary).

Last Name *First Name* *MI* *Birth date (mm/dd/yyyy)* *Relationship* Tobacco user? O Y O N Sex O M O F

Social Security Number *Height* *Weight* *Physician Name* *Primary Dentist Name*

Last Name *First Name* *MI* *Birth date (mm/dd/yyyy)* *Relationship* Tobacco user? O Y O N Sex O M O F

Social Security Number *Height* *Weight* *Physician Name* *Primary Dentist Name*

Last Name *First Name* *MI* *Birth date (mm/dd/yyyy)* *Relationship* Tobacco user? O Y O N Sex O M O F

Social Security Number *Height* *Weight* *Physician Name* *Primary Dentist Name*

Last Name *First Name* *MI* *Birth date (mm/dd/yyyy)* *Relationship* Tobacco user? O Y O N Sex O M O F

Social Security Number *Height* *Weight* *Physician Name* *Primary Dentist Name*

Waiver of Dependent Coverage (if none listed above), for dependents eligible under this plan: I realize that I can include my dependent(s) for consideration within my proposed coverage at this time but have chosen to exclude them. I understand that hereafter I may apply for dependent coverage only during an open enrollment period for my Plan or if a qualifying event occurs as defined in the Plan's Summary Plan Description.

Broker #__________

Step 4 Coverage Options and Selection

Medical Plan Options - Check with your employer for list of plans available.

- **Plan Name** $500 Classic
- **Plan Name** $1,000 Classic
- **Plan Name** $2,000 Classic
- **Plan Name** $3,500 Classic
- **Plan Name** $5,000 Classic
- **Plan Name** $3,000 HSA
- **Plan Name** $5,000 HSA
- **Plan Name** $1,000 Value
- **Plan Name** $3,000 Value
- **Plan Name** $7,350 Value
- **Plan Name** $0 Value

Dental Plan Options

Value Plan	100%/80%/50% Coverage	$1,000 Annual Max	No Ortho Coverage	$200 Vision Benefit
Premier Plan	100%/80%/50% Coverage	$1,500 Annual Max	With Ortho Coverage	$200 Vision Benefit

Step 5 Product Selection

Please indicate which plan you select for you and/or your dependent(s) below. Employee and any covered dependents must participate on the same medical plan.

	Medical *select from above*	Value Dental Plan	Premier Dental Plan	Other
Employee Only	Plan			N/A
EE & Spouse/Domestic Partner	Plan			N/A
EE & Dependent(s)	Plan			N/A
EE & Family	Plan			N/A

Step 6 Prior/Other Medical Insurance Information

This section must be completed to receive credit for prior medical coverage.

Within the last 12 months have you, your spouse, or your dependent(s) had any other medical coverage? ○ Y ○ N

If yes, please provide the following information:

Prior medical carrier name _____ Effective Date _____ End Date _____

Prior coverage type (check one of the following): ○ Employee ○ Spouse/Domestic Partner ○ Child(ren) ○ Family

On the day this coverage begins will you, your spouse, or any of your dependents be covered under any other medical health plan or policy, including another plan from this provider or Medicare? ○ Y ◉ N

If yes, attach sheet with name of other carrier, names and birth dates of all individuals covered by other plan including the effective date (mm/dd/yyyy) and end date (mm/dd/yyyy).

Step 7 Waiver of Coverage

I understand that by waiving coverage at this time I will not be allowed to participate unless I qualify at a special enrollment period, the next open enrollment period, or any time upon a qualifying event as defined in the Plan's Summary Plan Description.

I decline all coverage for (check all that apply): ○ Myself ○ Spouse/Domestic Partner ○ Dependent(s)

Declining coverage due to existence of other coverage (check all that apply):

○ Spouse/s Employer's Plan	○ Covered by Medicare	○ Covered by Medicare
○ I (we) currently have no other coverage	○ Individual Plan	○ Medicaid
○ COBRA from Prior Employment	○ Tri-Care	○ VA Eligibility

○ Other _____

Applicant Print:_____ Applicant Signature:_____ Date: / /

Step 8 Termination of Coverage

This section must be completed to receive credit for prior medical coverage.

I understand that by terminating coverage at this time, I will not be allowed to participate unless I qualify at a special enrollment period, the next enrollment period, or anytime upon a qualifying event as defined in the Plan's Summary Plan Description.

Step 9 Statement of Contingent Liability

This health coverage is issued by a self-funded multiple employer welfare arrangement. Coverage and benefits provided under a self-funded qualified multiple employer welfare arrangement are not protected by the Tennessee Life and Health Insurance Guaranty Association. If the self-funded qualified multiple employer welfare arrangement does not pay expenses that are eligible for payment under the plan for any reason, the employer or employee covered by the plan will be responsible for the payment of those expenses.

Applicant Print: _____ Applicant Signature: _____ Date: / /

Step 10 Signature

I understand that I am completing a joint application for coverage and requesting indicated group coverage for myself, and if the plan provides and I (we) have chosen, for my dependent(s). I authorize any required premium contributions to be deducted from earnings or payment for services rendered and owed to me which are considered the employees contribution. Otherwise, failure to remit payment will result in the termination of coverage as outlined in the plan documents. I understand that The Plan or any affiliated organizations are not bound by any statements I have made to any agent, or to any other persons, if those statements are not written or printed on this application and any attachments. I have been informed about : 1) the number, mix and distribution of network providers associated with the plan 2) existence of limitations and disclosures pertaining to my choice of certain healthcare providers, and 3) that The Plan and Affiliated organizations have contracted through a third party to negotiate with certain healthcare facilities to provide these services on a negotiated basis. I further acknowledge that coverage shall become effective only if approved by The Plan Sponsor/Administrator and only for services which are rendered on or after the effective date of coverage. A photocopy of this authorization shall be as effective and valid as the original. Please maintain a copy of this authorization for your records.

Applicant Print: _____ Applicant Signature: _____ Date: / /