Sumner County Board of Education

695 East Main Street • Gallatin, TN 37066

(615) 451-5214 • Fax: (615) 442-8262 • Benefits Portal *sumnerschools.org/benefits*

Email: benefits@sumnerschools.org

Note: You may change your benefit elections during the annual Open Enrollment period or during the year if you experience a Special Qualifying Event (SQE). A Life Event change permits employees to make certain mid-year benefit changes consistent with the qualifying event. You must consult your Benefits Administrator within 31 days from the date of the event to make changes. Qualifying Life Events include, but are not limited to:

- Changes in employee's marital status: Marriage, Divorce, Legal Separation, Annulment, Loss of Spouse.
- Changes in dependent status: Newborn, Adoption, Placement for Adoption, Death or Dependent, Eligibility Due to Age, Marriage.
- Changes in employment status: Employee, Spouse, Dependent.
- Changes in residence that affect available plan options: Employee, Spouse, Dependent.

To add a dependent due to birth or marriage, a copy of the birth certificate or marriage certificate is required within **31** days of event. In cases of adoption, please include a copy of the adoption order or Final Decree within **31** days of event.

To add a dependent due to loss of coverage, written documentation from your spouse's previous employer on company letterhead is required. The letter must include name(s) of the covered participant(s), the type(s) of coverage (i.e. medical, dental, vision) the date coverage ended as well as the reason coverage ended. Proof of co-ownership will be needed to process the request along with social security numbers (For example- bank statement, mortgage statement or a signed tax return). Please include copies of marriage certificate, birth certificate and social security cards.

To cancel coverage due to being newly eligible for other coverage, proof of other insurance is needed. Written documentation from your spouse's new employer on company letterhead is required. The letter must include the effective date of coverage, name(s) of covered participant(s) (if they are to be removed from the insurance), the type(s) of coverage (i.e. medical, dental, vision).

Within **31** days of the date the divorce decree is signed, you may elect any coverage you are losing under your spouse's plan. If you currently cover your spouse, you must drop his or her coverage for medical, dental, vision, and group term life, although you may continue to cover your children. You will need to complete the appropriate forms and provide a copy of the first and last pages of your certified divorce decree. You should also review your beneficiary designations for life insurance, retirement savings, and pension plans.

Within **31** days of the death, you may elect any coverage you are losing under your spouse's plan. If you currently cover your deceased dependent, you must drop his or her coverage for medical, dental, or vision although you may continue to cover the rest of your family. Again, you should review your beneficiary designations for life insurance, retirement savings, and pension plans. You will need to complete the appropriate forms and provide a copy of the certified death certificate.

Sumner County Board of Education
695 East Main Street • Gallatin, TN 37066
(615) 451-5214 • Fax: (615) 442-8262 • Benefits Portal sumnerschools.org/benefits
Email: benefits@sumnerschools.org

Benefits Special Qualifying Event Cancel / Enrollment / Change Form

Section A: Employee Information

Name: ____

Social Security Number: ________ - ________ - __________

Gender: ☐ F ☐ M **Marital Status:** ☐ S ☐ M ☐ D ☐ W

Date of Birth: _____/_____/______

Street Address: ____

City: ______________________________ **State:** _______________

ZIP: _________________ **Phone #:** (   ) ______-_____ _____

Email Address: ____

Special Qualifying Event (SQE): (Please check One)

☐ Marriage ☐ Loss of other coverage
☐ Divorce ☐ Qualify for other coverage
☐ Birth ☐ Court Order
☐ Adoption
☐ Change in employee or spouse employment.
☐ Loss of Child or Spouse

Date of Qualifying Event: ________________________________

Please submit all required supporting documentation and proof of qualifying event (Listed on Page 3 of this form)

Section B: Benefits Election *(Please complete all required dependent information in Section C)*

BCBS MEDICAL – I elect to: ☐ **Enroll** ☐ **Cancel** ☐ **Continue** coverage for: ☐ Employee ☐ Spouse ☐ Child(ren) ☐ Employee + Child(ren) ☐ Employee + Spouse ☐ Family

Please Elect Plan Type: ☐ **PPO Wellness** ☐ **PPO Standard** ☐ **CDHP Wellness** ☐ **CDHP Standard**

Please Elect Network: ☐ **Network P** ☐ **Network S** **(does not include TriStar facilities)**

If adding Medical Coverage, are you currently enrolled in Shared Savings? ☐ Yes ☐ No

MetLife DENTAL – I elect to: ☐ **Enroll** ☐ **Cancel** ☐ **Continue** coverage for: ☐ Employee ☐ Spouse ☐ Child(ren) ☐ Employee + Child(ren) ☐ Employee + Spouse ☐ Family

Please Elect Plan: ☐ **Enhanced Option** ☐ **Standard Option**

EyeMed VISION– I elect to: ☐ **Enroll** ☐ **Cancel** ☐ **Continue** coverage for: ☐ Employee ☐ Spouse ☐ Child(ren) ☐ Employee + Child(ren) ☐ Employee + Spouse ☐ Family

Please Elect Plan: ☐ **Enhanced Option** ☐ **Standard Option**

Section C: Dependent Information *(Please list dependents below you wish to Enroll or Cancel coverage for due to Special Qualifying Event. If more space is needed for additional dependent(s), please complete and attach an additional form.)*

Spouse/Domestic Partner Information

Last Name	First Name	Middle Initial	Social Security #	Date of Birth	Gender
				/ /	

Child Information #1

Last Name	First Name	Middle Initial	Social Security #	Date of Birth	Gender
				/ /	

Child Information #2

Last Name	First Name	Middle Initial	Social Security #	Date of Birth	Gender
				/ /	

Child Information #3

Last Name	First Name	Middle Initial	Social Security #	Date of Birth	Gender
				/ /	

Child Information #4

Last Name	First Name	Middle Initial	Social Security #	Date of Birth	Gender
				/ /	

Section D: Employee – Spouse – Child (Voluntary Term Life and AD&D)

Voluntary Term Life Insurance – I elect to: ☐ **Enroll** ☐ **Decline** coverage for: ☐ Spouse ☐ Child(ren)

Requested coverage amount:

☐ **Spouse** ________________________

☐ **Child** is set at flat benefit of $10,000

*Employee must be enrolled in Voluntary Term Life to elect/enroll Child and/or Spouse Voluntary Term Life Insurance.

Coverage Amounts:

Spouse Guaranteed Issue amount is up to $50,000; Spouse can receive up to 100% of employee amount in increments of $5,000 *Not to exceed $500,000.*

Child Guaranteed Issue amount is $10,000; Flat benefit of $10,000.

AD&D Benefit Schedule The full benefit amount is paid for loss of: • Life • Both hands or both feet or sight of both eyes • One hand and one foot • One hand and the sight of one eye • One foot and the sight of one eye • Speech and hearing **Additional Benefits** Accelerated Benefit • Waiver of Premium • Life Planning Financial & Legal Resources • Portability/Conversion • Education Benefit • Seat Belt/Air Bag Benefit • Repatriation

Section E: Beneficiary Designation (Basic & Voluntary Life)

Primary Beneficiary: ____ SSN#:_______-_______-________ Date of Birth: ____/___/____
Last First MI

Relationship: __________ % _______ Address: ____

Primary Beneficiary: ____ SSN#:_______-_______-________ Date of Birth: ____/___/____
Last First MI

Relationship: __________ % _______ Address: ____

Contingent Beneficiary: ____ SSN#:_______-_______-________ Date of Birth: ____/___/____
Last First MI

Relationship: __________ % _______ Address: ____

Contingent Beneficiary: ____ SSN#:_______-_______-________ Date of Birth: ____/___/____
Last First MI

Relationship: __________ % _______ Address: ____

If more than one beneficiary is named, the beneficiaries shall share benefits equally unless otherwise stated above. If indicating benefit percentages, the percentages must total 100% for Primary Beneficiaries and 100% for Secondary Beneficiaries. Some states have laws regarding beneficiary designation. Please consult your employer/benefits administrator for additional information. If you need to designate more beneficiaries than space will allow, please include this information on a separate piece of paper and submit it with this form, clearly stating your name.

Section F: Employee Authorization

By signing this application, I attest that I and/or my dependent(s) are eligible to cancel/enroll in coverage because we qualify under the Special Qualifying Event provisions as identified above. I confirm that all of the information above is true. I know that I can lose my insurance if I give false information. I may also face disciplinary and legal charges. I understand that if my dependent loses eligibility, coverage will terminate at the end of the month in which the loss of eligibility occurs. I further understand that it is my responsibility to notify my Benefits Coordinator of the loss of eligibility and I will be held responsible for any claims paid in error for any reason. I authorize my employer to take deductions from my paycheck to pay for my benefit costs. Finally, I authorize healthcare providers to give my insurance carrier the medical and insurance records for me and my dependents.

____

Employee Signature Date