

# Application for Membership Metropolitan Employee Benefit System

**INSTRUCTIONS:** Complete this form and bring it with you to the New Employee Orientation. For more information, call Metro Human Resources at (615) 862-6700.

## PART 1 – About You

Name:		SSN:
Date of Birth:	Date Employed:	
Metro Department:		

## PART 2 – About Your Employment

Please check any plans of which you are currently a member, receiving benefits from or have a vested pension benefit due:

- The Metro Plan
- Old City Plan
- Old County Plan
- Electric Power Board Plan (NES) \*
- Any retirement plan for Teachers \*

If you are a member of one of these plans other than the Metro Plan, you are not eligible to be member of the Metro Benefit System.

\*Service with these plans cannot be connected to your Metro service.

Have you previously been employed by Metropolitan Government?

No  Yes

Which Department? \_\_\_\_\_

Dates of Employment \_\_\_\_\_

## PART 3 – Acknowledgement

**I understand that as a condition of my employment I shall participate as a member of the Metropolitan Employee Benefit System, the terms and conditions of which I hereby accept.**

Signature:	Date:
HR Staff Member:	Date:

**Eligibility Date:**

# New Employee Benefit Election Form

Ins eff Date \_\_\_\_\_

Benefit	check one per benefit	check one per benefit
Medical Plan	<input type="checkbox"/> BCBS PPO <input type="checkbox"/> Cigna Choice Fund <input type="checkbox"/> Opt Out (must provide proof of other coverage)	<input type="checkbox"/> Single <input type="checkbox"/> Family
Dental Plan	<input type="checkbox"/> Limited PPO <input type="checkbox"/> Premier <input type="checkbox"/> Opt Out (must provide proof of other coverage)	<input type="checkbox"/> Single <input type="checkbox"/> Family
Vision Plan	<input type="checkbox"/> Basic <input type="checkbox"/> Enhanced	<input type="checkbox"/> Single <input type="checkbox"/> Family

Are you covered as a dependent on the insurance of another Metro employee (spouse or parent)? If yes, complete information.

Name: \_\_\_\_\_ Department: \_\_\_\_\_

Supplemental Life	<input type="checkbox"/> Enroll me in the amount of \$ _____ (multiples of \$10,000 up to a maximum of \$200,000) <b>Note:</b> If you chose not to enroll now, but enroll at a later date, you will be subject to Evidence of Insurability.	
Dependent Life	<input type="checkbox"/> Enroll my dependents	<b>Note:</b> If you chose not to enroll now, but enroll your dependents at a later date, they will be subject to Evidence of Insurability.
Short-Term Disability	<input type="checkbox"/> Enroll me	<b>Note:</b> If you chose not to enroll now, but enroll at a later date, a late-enrollment penalty may apply.
Long-Term Disability	<input type="checkbox"/> Enroll me	<b>Note:</b> If you chose not to enroll now, but enroll at a later date, a late-enrollment penalty may apply.
Flexible Spending Accounts (FSAs)	<b>Health Care FSA</b> Annual election amount \$ _____	<b>Dependent Care FSA</b> Annual election amount \$ _____
Before-Tax Premium Savings Plan	If you elect insurance, you are automatically enrolled in the before-tax premium savings plan which saves you tax dollars on the cost of your health insurance premiums. If you <b>do NOT wish to participate</b> in this program, please initial here: _____	

## Dependent Information — List all dependents you want to cover.

Name	SSN	Spouse / Child	Male / Female	Birth Date	Desired Coverage
					<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
					<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
					<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
					<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
					<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
					<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
					<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
					<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision

**Acknowledgement** — I attest and affirm that each person named above is related to me by law and is my true legal dependent and any dependent child listed is not eligible for his/her own employer-sponsored health plan. I authorize the adjustment of my annual taxable salary based on my elections above. I understand that my elections will remain in effect from my insurance effective date through the remainder of the plan year unless I experience an eligible change in status.

**Employee Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Print Employee Name: \_\_\_\_\_ SS #: \_\_\_\_\_ DOB: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Department: \_\_\_\_\_



## Eligible Spouse/Dependent Certification Form

**Instructions:** To cover your Spouse and/or Dependent Child(ren) on Metro's insurance plans, you must confirm their eligibility. Please complete this Certification Form by indicating whether your Spouse and/or Dependent Child(ren) meet the following criteria.

### Qualification of Marital Status

Spouse's Name:

- I am legally married to my spouse named above and we are NOT divorced, legally separated or common-law married.
- My spouse is NOT on active duty in the armed forces of any country or international organization, or a member of a civilian force auxillary to any military force.

### Qualification of Dependent Child Status

Dependent Children's Names:

The dependent child(ren) listed above meet the following criteria and each child:

- Is my child by birth; legal adoption or has been placed with me for adoption; is my stepchild whose primary residence is with me and my spouse, is my child by legal guardianship, court order or Qualified Medical Child Support Order (QMCSO);
- Is UNDER the age of 26;
- Is NOT eligible for his or her own employer-sponsored health plan;
- And is NOT eligible for benefits as a Metro employee; and
- Is NOT on active duty in the armed forces of any country or international organization, or a member of a civilian force auxillary to any military force.

### Signature

I certify the information I have provided is true and correct and that I am responsible for updating this information in the event it changes. I understand the information will be reviewed and a determination will be made regarding my dependent's eligibility for coverage. I acknowledge that falsifying this information or failing to update this information can lead to cancellation of my dependent's coverage and disciplinary action up to and including termination of employment. Submission of this form does not guarantee eligibility for benefits.

\_\_\_\_\_ Date: \_\_\_\_\_



# Metro Nashville

## Life Insurance Beneficiary Designation/Change

**Forward to:**  
**Metro Human Resources**  
**Attention: Benefit Services**  
**P.O. Box 198349**  
**Nashville, TN 37219-8349**

Before executing this form refer to the other side. Please keep a copy for your records.

Group Policyholder Name <b>Metropolitan Government of Nashville and Davidson County</b>	Group Policy Number 46767	<input checked="" type="checkbox"/> Employee <input type="checkbox"/> Retiree	Employee/Retiree Social Security Number  Department:
Employee/Retiree Name and Address		Coverage(s) this form applies to: <ul style="list-style-type: none"> <li>• Basic Life Insurance</li> <li>• Supplemental Life</li> </ul>	

Subject to the terms of the above numbered Group Policy(ies), I request that any sum becoming payable by reason of my death be payable to the following beneficiary(ies). It is my understanding that this designation shall operate so as to revoke all designations of beneficiary and all election of optional methods of settlement previously made by me under said Policy(ies). If this Designation of Beneficiary refers only to a Group Life Insurance Policy and if I am also insured for Supplemental and/or Group Accidental Death coverage, this designation shall apply to those coverages.

Employee/Retiree Signature	Date
----------------------------	------

Beneficiary Name and Address	<input checked="" type="checkbox"/> <b>Primary Beneficiary*</b>	<input type="checkbox"/> <b>Basic Life Insurance</b>	<input type="checkbox"/> <b>Supplemental Life Insurance</b>
------------------------------	---	--	---

Relationship	Social Security Number	Date of Birth (MM/DD/YYYY)	Percentage
--------------	------------------------	----------------------------	------------

Beneficiary Name and Address	<input type="checkbox"/> <b>Primary Beneficiary* or</b>	<input type="checkbox"/> <b>Contingent Beneficiary**</b>	<input type="checkbox"/> <b>Basic Life Insurance</b>	<input type="checkbox"/> <b>Supplemental Life Insurance</b>
------------------------------	---	--	--	---

Relationship	Social Security Number	Date of Birth (MM/DD/YYYY)	Percentage
--------------	------------------------	----------------------------	------------

Beneficiary Name and Address	<input type="checkbox"/> <b>Primary Beneficiary* or</b>	<input type="checkbox"/> <b>Contingent Beneficiary**</b>	<input type="checkbox"/> <b>Basic Life Insurance</b>	<input type="checkbox"/> <b>Supplemental Life Insurance</b>
------------------------------	---	--	--	---

Relationship	Social Security Number	Date of Birth (MM/DD/YYYY)	Percentage
--------------	------------------------	----------------------------	------------

Beneficiary Name and Address	<input type="checkbox"/> <b>Primary Beneficiary* or</b>	<input type="checkbox"/> <b>Contingent Beneficiary**</b>	<input type="checkbox"/> <b>Basic Life Insurance</b>	<input type="checkbox"/> <b>Supplemental Life Insurance</b>
------------------------------	---	--	--	---

Relationship	Social Security Number	Date of Birth (MM/DD/YYYY)	Percentage
--------------	------------------------	----------------------------	------------

If a Trust has been named as a beneficiary above, please complete the following:

Trustee's Full Name: \_\_\_\_\_

Trustee's Address: \_\_\_\_\_

Title of Trust Agreement: \_\_\_\_\_ Date of Agreement: \_\_\_\_\_

**\*If more than one Primary Beneficiary is named, the Primary Beneficiaries shall share equally unless otherwise indicated above.**  
**\*\*Contingent Beneficiary(ies) will only receive proceeds if all Primary Beneficiaries have predeceased the Insured. If you are naming more than one Contingent Beneficiary at 100% each, please indicate 1<sup>st</sup> contingent, 2<sup>nd</sup> contingent, 3<sup>rd</sup> contingent, etc. in the order of precedence.**

\*BENEFICIARIES\*