Metro Nashville Human Resources

Annual Enrollment Guide for 2005 Benefits

Oct. 11 to 29, 2004

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About This Guide

The Annual Enrollment Guide provides a variety of information to help you enroll in your Metro employee benefits for 2005. If the information in this Guide differs from the official plan documents, the plan documents will govern. This Guide does not constitute an offer of employment or a promise to provide any particular benefit. Metro Nashville reserves the right to change its employee benefit program at any time. For more information, call Metro Human Resources at (615) 862-6700.

Americans with Disabilities Act Statement: To request an alternative copy of this guide, call Metro Human Resources at (615) 862-6640.

2005 Benefit *Resources* Directory

Benefit	Contact	Website	Phone
Medical PPO	BlueCross/BlueShield PPO	www.bcbst.com	(800) 367-7790
Medical HMO	CIGNA HMO	www.cigna.com	(800) 244-6224
Medical HMO and/or Medicare Advantage Plan	HealthSpring HMO and HealthSpring Alternative	www.myhealthspring.com	(800) 881-9466
Dental Plan	Delta Dental of Tennessee	www.deltadentaltn.com	(800) 223-3104 (615) 255-3175
Vision Plan	VSP	www.vsp.com	(800) 877-7195
Optional Long-Term Care Insurance	Prudential Insurance Company	www.prudential.com/ insurance/life/ltc	(800) 732-0416
Basic Life Insurance	Metro Human Resources	www.nashville.gov	(615) 862-6700
Metro Pension Plan	Metro Human Resources	www.nashville.gov	(615) 862-6700
MetroMax 457 Deferred Compensation Plan	ING (plan administrator)	www.ingretirementplans. com/custom/nashville	(800) 584-6001 (615) 291-8317
Social Security and Medicare	Social Security Administration	www.ssa.gov	Your local Social Security office
Other Information	Metro Human Resources	www.nashville.gov	(615) 862-6700

Updates for 2005

NEW! **HealthSpring Alternative Plan**	Metro is pleased to offer HealthSpring Alternative, a new medical plan option for Medicare Part B participants and their dependents. You'll find information on the new option in your Enrollment Packet. To speak to a HealthSpring representative about the plan, attend an Ask & Enroll Day (see Page 5) or contact HealthSpring (see Page 2).
Long Term Care Insurance	Your packet also includes information on long-term care insurance, which was added to Metro's benefit program last spring. Long-term care insurance provides a measure of financial protection if you or a family member require long-term care in any one of a variety of settings, including nursing homes, assisted-living facilities, hospice facilities, or even your own home. Long-term care is not just for retirees or those nearing retirement. About 40% of all people who receive long-term care are between the ages of 18 and 64. For details on this valuable coverage, read the "Optional Long Term Care Insurance" insert in your Enrollment Packet or contact the insurance carrier (see Page 2). And remember to file the insert in your *Inside Metro Human Resources Guide* (3-ring binder), behind the Income Protection tab.
Life Insurance "Summary of Coverage" and "Group Coverage Plan"	These documents are included in your Enrollment Packet and provide details on life insurance under Metro's benefit program. Please keep the documents in your benefits binder for reference.
Other Binder Updates	Your *Inside Metro Human Resources Guide* was designed to be updated easily and economically. Other than the documents mentioned above, there are relatively few updates to the binder contents for 2005. To help control costs, we have printed these updates on a single sheet, which is part of your Enrollment Packet. Please read the updates carefully and note the changes in the appropriate pages of your binder.

Is Your Beneficiary Information Current?

To update your beneficiary information for life insurance, complete the form on Page 11 and submit it with your 2005 Election Form or whenever you have a change of beneficiary for life insurance in the future.

To change beneficiaries for other benefits, contact Metro Human Resources at (615) 862-6700.

How to *Enroll* in 2005 Benefits

- ❑ Review your *Personal Benefit Statement* and refer to it when electing your 2005 benefits. You'll find your Personal Benefit Statement attached to your 2005 Benefit Election Form.

- ❑ Refer to this *Enrollment Guide* for:
  - 2005 insurance rates
  - 2005 medical plan comparison chart
  - Beneficiary Designation Form for life insurance
  - Contact information for each Metro benefit

- ❑ For benefit details, read your *Inside Metro Human Resources Guide* (binder) or contact the insurance carriers or Metro Human Resources. Be sure to update your binder with the information in your Enrollment Packet.

- ❑ Attend an Ask & Enroll Day (attendance is optional) to talk one-on-one about your benefits with the insurance carriers and Metro Human Resources representatives. You can also submit your 2005 Election Form at any Ask & Enroll Day.

- ❑ Complete the *2005 Benefit Election Form* (see accompanying document) and **submit it by October 29, 2004,** by any of the following means:
  - In person (by 4:30 p.m.) to **Metro Human Resources, 222 Third Avenue North, Suite 200, Nashville**
  - By mail to **Metro Human Resources, P.O. Box 198589, Nashville, TN 37219-0589**
  - In person at any Ask & Enroll Day (see Page 5 for a calendar)
  - By fax at **(615) 880-3401** (fax only the Election Form side of the page, not the instruction side)
  - Online at **www.nashville.gov** (click "Annual Enrollment")

- ❑ If you have no changes to your benefit elections or dependent information for 2005, you do not need to submit an Election Form during this Annual Enrollment. However, please read the Election Form instructions carefully before deciding whether or not you need to submit an Election Form.

- ❑ Keep a personal copy of all forms you submit (Election Form as well as Beneficiary Designation Form, if applicable). A confirmation statement of your 2005 elections will be mailed to your home at the close of Annual Enrollment.

Remember: To change your benefit elections for 2005,
you must submit your Election Form by October 29, 2004.

Ask & Enroll Days

Questions about your 2005 benefits and enrollment? Want to talk one-on-one with plan representatives about your benefits and have the option to enroll on the spot? Then come to any one of eight convenient Ask & Enroll Days starting October 12 (see calendar below).

At Ask & Enroll Days, representatives from the insurance carriers and Metro Human Resources will be on hand to answer questions and collect Election Forms. Be sure to bring your Enrollment Packet with you. Or, if you already know what changes you want for 2005, just drop off your completed 2005 Election Form. It's that easy.

Ask & Enroll Days are voluntary. You don't have to attend to enroll (see Page 4 for other enrollment options). If you can attend, you should, especially if you have questions about your benefits. Or, if you can't go to an Ask & Enroll Day, watch Nashville Cable Channel 3 for more information about 2005 benefits and enrollment (see your cable listings for times).

Ask & Enroll Days Calendar

Date	Time	Location*
Tuesday, Oct. 12	7 a.m. – 4 p.m.	General Hospital, Room 9 BC 1818 Albion Street
Wednesday, Oct. 13	7 a.m. – 4 p.m.	Metro Police – South Station Community Room 5101 Harding Place
Thursday, Oct. 14	1 p.m. – 8 p.m.	Antioch Community Center 5023 Blue Hole Road
Friday, Oct. 15	7 a.m. – Noon	Metro Water Department, Community Room 1616 Third Avenue North
Tuesday, Oct. 19	1 p.m. – 8 p.m.	Metro Police – North Station Community Room 2231 26th Avenue North
Wednesday, Oct. 20	7 a.m. – 4 p.m.	Metro Public Works Department Roll Call Room 740 South 5th Street
Thursday, Oct. 21	1 p.m. – 7 p.m.	Randalls Learning Center 3501 Byron Avenue
Friday, Oct. 22	8 a.m. – 1 p.m.	Metro Parks Department Recreation Conference Room 2565 Park Plaza

***For directions, call Metro Human Resources at (615) 862-6700.**

2005 Health Plan Insurance *Rates*

Effective January 1, 2005

See the category that applies to you. Metro pays about 75% of the cost of your medical and dental coverage. You pay the rest. The vision plan and long-term care insurance are optional. You pay the full cost of this coverage at group rates. Group rates are generally lower than individual rates.

	Coverage Level	BC/BS PPO	CIGNA HMO	HealthSpring HMO	HealthSpring Alternative
Monthly Medical Plan Rates	Single (pensioner or dependent only) without Medicare	$111.00	$101.48	$91.24	N/A
	Family	278.00	246.78	223.50	N/A
	Pensioner with Medicare	64.00	45.96	24.74	17.24
	Pensioner and Spouse both with Medicare	123.00	111.48	49.50	34.50
	Pensioner without Medicare, Spouse with Medicare	173.00	136.08	115.98	108.48
	Pensioner with Medicare, Spouse without Medicare	173.00	136.08	115.98	108.48
	Pensioner with Medicare and Child(ren) without Medicare	123.00	136.08	58.96	51.46
	Pensioner Split [1]	167.00	145.30	132.26	132.26
	Pensioner, Spouse and Child(ren) all with Medicare	183.00	111.48	83.70	68.70

Monthly Dental Plan Rates	Single	Family
	$0.00 (Metro pays 100%)	$31.84

Monthly Vision Plan Rates [2]	Single	Family	Split [1]
	$5.30	$10.76	$5.46

Long-Term Care Insurance Rates [2]	Contact Prudential at **www.prudential.com/insurance/life/ltc** or call **800-732-0416.**

[1] Split coverage is available to Metro pensioners and employees who: 1) are married to a Metro pensioner or employee, 2) are enrolled in the same Metro medical and/or vision plan as their spouse, and 3) enroll dependent child(ren) in the plan(s). (All three requirements must be met.)

[2] The vision plan and long-term care insurance are optional benefits. You pay the full cost of this coverage at group rates. Group rates are generally lower than individual rates.

2005 Dental Plan *Highlights*

Note: This chart is a summary only. If the information differs from that of the official plan documents, the plan documents will govern. For details, contact the insurance carrier.

Benefit	Delta Premier Plan In-Network	Delta Premier Plan Out-of-Network	Delta Network Preferred Plan [3]
Calendar year maximum	$1,000 per person	$1,000 per person	No annual maximum
Calendar year deductible	$75 per person; $225 per family	$75 per person; $225 per family	No deductible
Class I — preventive and diagnostic care (initial and periodic exams, cleanings, routine X-rays)	100%; no deductible	100% of the maximum plan allowance[1] (MPA); no deductible	100% for most benefits (except Space Maintainer)
Class II — basic restorative care (fillings, extractions, root canal, periodontal treatment)	80%; no deductible	80% of MPA[1]; no deductible	100% of some services; flat dollar amount set for other services
Class III — major restorative care (crowns, dentures, bridges)	50% after deductible	50% of MPA[1] after deductible	Flat dollar amount set for most services
Class IV — Orthodontia (braces)	50% after deductible; $100 annual deductible[2]; $1,000 lifetime maximum	50% of MPA[1] after deductible; $100 annual deductible[2]; $1,000 lifetime maximum	Flat dollar amount set for all services
Class V — TMJ	50% after deductible; $100 annual deductible[2]; $750 lifetime maximum	50% of MPA[1] after deductible; $100 annual deductible[2]; $750 lifetime maximum	Not a covered benefit

[1] Maximum plan allowance (MPA). You are not responsible for charges over the MPA if you go to a participating Delta dentist. You are responsible for charges over the MPA if you go to a non-participating dentist.

[2] These deductibles are in addition to the plan deductible.

[3] Under the Preferred Plan, you must visit a Preferred Plan dentist or you will not receive benefits, however you do not have to choose a primary care dentist. No Out-of-Network benefits available with this plan.

2005 Medical Plan Highlights

Note: This chart is a summary only. If the information differs from that of the official plan documents, the plan documents will govern. For details, contact the insurance carrier.

Covered Benefit	BC/BS PPO In-Network Blue Network P	BC/BS PPO Out-of-Network [1] Provider of Your Choice	Cigna HMO	HealthSpring HMO [2]	HealthSpring Alternative [2]
Deductible	None	$200 individual, $600 family. **Note:** deductible required for out-of-network care and services.	None	None	None
Coinsurance	Plan pays 80% of maximum allowable charges for most services	Plan pays 60% of maximum allowable charges for most services after deductible. You pay any amount over maximum allowable charge.	None	None	None
Annual out-of-pocket maximum	$1,000 individual, $2,000 family	$5,000 individual, $10,000 family	$1,000 individual, $2,000 family Note: Only mental health and substance abuse copays apply to out-of-pocket max	$2,000 individual, $4,000 family Note: Medical, surgical and behavioral health copays apply to out-of-pocket max	$2,000 individual, $4,000 family Note: Medical, surgical and behavioral health copays apply to out-of-pocket max
Hospital (semi-private room, supplies, drugs, routine X-rays, tests)	80% of maximum allowable charges	60% of maximum allowable charges	100%	100%	$250 copay each day for days 1 to 5
Emergency Room care	80% after $50 copay	60% of maximum allowable charges after $50 copay	$50 copay (life- or limb-threatening or if referred by PCP)	$50 copay (true emergency); must contact PCP next business day	$50 copay (true emergency); must contact PCP next business day
Surgery, office visits, anesthesia, consults, treatment, second surgical opinion	80% after $10 copay per visit	60% of maximum allowable charges after $10 copay per visit	100% after $10 copay per visit with PCP or specialist	100% after $10 copay with PCP and specialist	$200 copay for out-patient surgery
Maternity	80% of maximum allowable charges after $10 copay per visit	60% of maximum allowable charges after $10 copay per visit	$10 copay for first visit to confirm pregnancy; all later visits 100%	$10 copay for first OB visit; all later visits 100%	$10 copay for first OB visit; all later visits 100%
Prescription drugs	$10 copay for generics, $20 copay for brand names; certain drugs require pre-authorization; quantities of some drugs may be limited Maintenance drugs: 102-day supply for 2 copays (prescriptions must be on BCBST maintenance drug list); drugs not on the maintenance list limited to a 34-day supply at retail pharmacies Home Delivery Program (mail-order): 102-day supply for 2 copays	$10 copay for generics plus charges above usual costs; $20 copay for brand names plus charges above usual costs; certain drugs require pre-authorization; quantities of some drugs may be limited Maintenance drugs: 102-day supply for 2 copays (prescription must be on BCBST maintenance drug list); drugs not on the maintenance list limited to a 34-day supply at retail pharmacies	$10 copay for generic (30-day supply); $20 copay for brand name (30-day supply). If generic is available but you request brand name, you pay $20 copay plus difference between generic and brand name. Coverage for formulary drugs only unless pre-authorized. Mail-order program: 90-day supply for 3 copays (coverage for formulary drugs only)	$10 copay for generic, $20 copay for preferred brand name, $35 copay for non-preferred brand name (30-day supply) Mail order program: 90-day supply for 3 copays; maintenance medications only	$10 copay for generic, $20 copay for preferred brand name, $35 copay for non-preferred brand name (30-day supply) Mail order program: 90-day supply for 3 copays; maintenance medications only
Hospice care	80%; must be approved provider	60% of maximum allowable charges	100%	100%; $10,000 calendar year maximum benefit	100%; $10,000 calendar year maximum benefit
Home health visits	80% of maximum allowable charges	60% of maximum allowable charges	100%	100% after $10 copay per visit; up to 100 visits per calendar year	100% after $10 copay per visit; up to 100 visits per calendar year
Medical equipment (DME, wheel chairs, crutches, etc)	80% of maximum allowable charges	60% of maximum allowable charges	100%	80% of allowed charges, up to a combined benefit limit of $1,500 per calendar year	80% of allowed charges, up to a combined benefit limit of $1,500 per calendar year
Preventive physical exams	Not covered	Not covered	100% after $10 copay	100% after $10 copay per visit	100% after $10 copay per visit
Allergy injections	80% of maximum allowable charges after $10 copay for physician consultation	60% of maximum allowable charge after $10 copay for physician consultation	100% after $10 copay per visit or the actual charge, whichever is less	100% after $10 copay per visit	100% after $10 copay per visit
Well-baby care	Routine care until age 2; annual checkups through age 6 paid at 80% after $10 copay	Routine care until age 2; annual checkups through age 6 paid at 60% after $10 copay	100% after $10 copay per visit	100% after $10 copay per visit	100% after $10 copay per visit
Immunizations	Covered if required by public school guidelines through age 6; paid at 80% after $10 copay	Covered if required by public school guidelines through age 6; paid at 60% after $10 copay	$10 copay per visit	$10 copay per visit	$10 copay per visit
Vision and hearing tests (children under 17)	Not covered	Not covered	$10 copay; services by PCP	$10 copay for screening by PCP	$10 copay for screening by PCP

[1] Benefits for out-of-network services may be significantly less than in-network benefits. You will be responsible for coinsurance as well as amounts above the maximum allowable charges (as determined by BC/BST).

[2] You must live in one of the following Tennessee counties to enroll in HealthSpring (counties with asterisk have NO participating HealthSpring providers at the time of this printing): Bedford, Cannon, Cheatham, Coffee, Davidson, Dekalb, Dickson, Franklin*, Hickman, Humphreys*, Lawrence*, Lewis*, Macon, Marshall, Maury, Montgomery, Moore*, Robertson, Rutherford, Smith, Sumner, Stewart*, Trousdale, Warren, Wayne*, Williamson, Wilson. **NOTE: HealthSpring will update the list of counties as changes occur. Contact HealthSpring for the latest information.**

Covered Benefit	BC/BS PPO In-Network Blue Network P	BC/BS PPO Out-of-Network [1] Provider of Your Choice	Cigna HMO	HealthSpring HMO [2]	HealthSpring Alternative [2]
Skilled nursing facility	80%; 100-day maximum per person per year (must immediately follow 3-day hospital stay)	80%; 100-day maximum per person per year (must immediately follow 3-day hospital stay)	100%; 60-day maximum per person per year no deductible or copays	100%; up to 100 days per calendar year	100%; up to 100 days per calendar year
Radial keratotomy	80% (Lasik surgery not covered)	60% of maximum allowable charge; Lasik surgery not covered	Not covered	Not covered	Not covered
Custom-built shoes	80%, up to $1,500 lifetime maximum (includes repair and maintenance)	60%, up to a $1,500 lifetime maximum (includes repair and maintenance)	100%, up to $1,500 lifetime maximum (includes repair and maintenance)	80% of allowed charges, up to a combined benefit limit of $1,500 per calendar year. Benefit, annual replacement of shoes and/or inserts for diabetic members only.	80% of allowed charges, up to a combined benefit limit of $1,500 per calendar year. Benefit, annual replacement of shoes and/or inserts for diabetic members only.
Temporomandibular joint syndrome (TMJ)	Surgery covered as any other surgical procedure; 80% in-network; 50% non-surgical; $2,000 annual maximum; $4,000 lifetime maximum	Surgery covered as any other surgical procedure: 60% out-of-network; 50% non-surgical; $2,000 annual maximum; $4,000 lifetime maximum	$10 copay per visit for physician and facility charges, inpatient or outpatient; no coverage for appliances or orthodontia (braces)	100% after $10 copay per visit for physician and facility charges; maximum benefit of $2,000 per calendar year for authorized TMJ treatment	100% after $10 copay per visit for physician and facility charges; maximum benefit of $2,000 per calendar year for authorized TMJ treatment
Chiropractic services	50% of maximum allowable charge, up to $2,000 maximum per person per year	50% of maximum allowable charges, up to $2,000 maximum per person per year	100% after $20 copay per visit; PCP referral required; maximum of 90 combined chiropractic/physical therapy visits per year	100% after $10 copay per visit; no PCP referral required; 20 visits per calendar year	100% after $10 copay per visit; no PCP referral required; 20 visits per calendar year
Acupuncture	50% of maximum allowable charges; $1,000 maximum per person per year	50% of maximum allowable charges; $1,000 maximum per person per year	Not covered	Not covered	Not covered
Organ transplants	Special provisions apply to transplant coverage	Special provisions apply to transplant coverage	100% for most covered medical expenses and related services	100%; must be pre approved by HealthSpring	100%; must be pre-approved by HealthSpring
Physical therapy	80% of maximum allowable charges	60% of maximum allowable charges	100% after $20 copay per visit; maximum of 90 combined chiropractic/physical therapy visits per year	100% after $10 copay per visit; 30 visits per calendar year	100% after $10 copay per visit; 30 visits per calendar year
In-line-of-duty	Covered, subject to PPO and non-PPO provisions and copays	Covered, subject to PPO and non-PPO provisions and copays	Covered, subject to copays and HMO guidelines	Covered; subject to copays and HMO guidelines	Covered; subject to copays and HMO guidelines
Selection of physicians	Above benefits apply when you use in-network provider	Above benefits apply when you use out-of-network provider	All care must be received from PCP or PCP-referred specialist (women have open access to participating OB/GYN)	All care must be received from PCP or PCP-referred specialist	All care must be received from PCP or PCP-referred specialist
Non-routine lab/X-ray	80% of maximum allowable charges	60% of maximum allowable charges	Covered under office-visit copay	Covered under office-visit copay	$75 copay for MRI, CT scan, PET scan, and nuclear medicine
Mental health inpatient	80% of maximum allowable charges; pre-authorization required; maximum of 45 days per year	60% of maximum allowable charges; pre-authorization required; maximum of 45 days per year	100%; maximum of 30 days of combined mental health / substance abuse visits per year	100%; maximum of 30 days of combined mental health / substance abuse per calendar year	100%; maximum of 30 days of combined mental health / substance abuse per calendar year
Mental health outpatient	80% of maximum allowable charges; no pre-authorization required; 50-visit maximum per year combined with substance abuse	60% of maximum allowable charges; 50-visit maximum per year combined with substance abuse; no pre-authorization required	100% after $10 copay per visit; maximum of 25 visits per year	100% after $10 copay per visit; maximum of 30 visits combined mental health / substance abuse per calendar year	$250 copay for in-patient mental health; $10 copay for out-patient
Substance abuse inpatient	80% of maximum allowable charges; pre-authorization required; 1 admission per 90 days	60% of maximum allowable charges; 1 admission per 90 days; pre-authorization required	100% after $50 copay per day; maximum of 30 days of combined mental health / substance abuse visits per year	100%; maximum of 30 days of combined mental health/substance abuse per calendar year	100%; maximum of 30 days of combined mental health/substance abuse per calendar year
Substance abuse outpatient	80% of maximum allowable charges; no pre-authorization required; 50-visit maximum per year combined with mental health	60% of maximum allowable charges; no pre-authorization required; 50-visit maximum per year combined with mental health	100% after $15 copay for the first two visits; $25 copay thereafter, up to 20 visits maximum per year	100% after $10 copay per visit; maximum of 30 visits combined mental health / substance abuse per calendar year	100% after $10 copay per visit; maximum of 30 visits combined mental health / substance abuse per calendar year
Group therapy	Covered as mental health outpatient	Covered as mental health outpatient	100% after $15 copay per visit; maximum of 40 combined mental health / substance abuse visits per year	100% after $10 copay per visit; maximum of 30 visits combined mental health / substance abuse per calendar year	100% after $10 copay per visit; maximum of 30 visits combined mental health / substance abuse per calendar year

[1] Benefits for out-of-network services may be significantly less than in-network benefits. You will be responsible for coinsurance as well as amounts above the maximum allowable charges (as determined by BC/BST)

[2] You must live in one of the following Tennessee counties to enroll in HealthSpring (counties with asterisk have NO participating HealthSpring providers at the time of this printing): Bedford, Cannon, Cheatham, Coffee, Davidson, Dekalb, Dickson, Franklin*, Hickman, Humphreys*, Lawrence*, Lewis*, Macon, Marshall, Maury, Montgomery, Moore*, Robertson, Rutherford, Smith, Sumner, Stewart*, Trousdale, Warren, Wayne*, Williamson, Wilson. **NOTE: HealthSpring will update the list of counties as changes occur. Contact HealthSpring for the latest information.**

Aetna Life Insurance Company
Designation of Beneficiary
INSTRUCTIONS

- Unless otherwise expressly provided in this Designation of Beneficiary form, if any named beneficiary predeceases me, the life proceeds shall be payable equally to the remaining named beneficiary or beneficiaries. If no named beneficiary survives me, any sum becoming payable under said Group Policy(ies) by reason of my death shall be payable as prescribed in said Group Policy(ies).
- If this Designation of Beneficiary provides for payment to a trustee under a trust agreement, Aetna Life Insurance Company shall not be obliged to inquire into the terms of the trust agreement and shall not be chargeable with knowledge of the terms thereof. Payment to and receipt by the trustee shall fully discharge all liability of said Insurance Company to the extent of such payment.
- If you live in one of the following community property states - Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, or Wisconsin – your spouse may have a legal claim for a portion of the life insurance benefit under state law. If you name someone other than your spouse as beneficiary, payment of the death benefit may be delayed until your spouse's claim is resolved. If you make the beneficiary someone other than your spouse, it may be a good idea to complete the spousal consent section, which allows the spouse to waive his or her rights to any community property interest in the benefit.

Instructions

- Please use only black ink to complete this form.
- If you make a mistake in completing this form, line out the erroneous information, add the correct information and initial the correction. **The printed material on this form should not be deleted or altered in any way.**
- In all cases, the relationship of the beneficiary and the beneficiary's social security number should be included with the beneficiary designations.
- If beneficiary is to be contingent, be sure to check the appropriate box. A Contingent Beneficiary will receive benefits only if the Primary Beneficiary(ies) do not survive the insured. If naming more than one Contingent Beneficiary at 100% each, please indicate 1st contingent, 2nd contingent, 3rd contingent, etc.
- If a married woman is named beneficiary, her full legal name should be shown. **For example:** Mary J. Smith, not Mrs. John J. Smith. Likewise, if this form is to be signed by a married woman, she should sign her full legal name.
- If a minor child is named beneficiary, the date of birth along with the social security number must be given.
- When two or more beneficiaries are named, and they are not to share the benefits equally, enter the percentage each beneficiary is to receive on the form in the space provided. **Dollars and cents should not be specified. When added together, the sum of the percentages going to the two or more named beneficiaries should not total more than 100%.**
- If a trustee is named beneficiary, show the exact name of the trust, date of the trust agreement, and the name and address of the trustee. **For example:** The John J. Smith Revocable Life Insurance Trust, dated January 1, 1994. John Smith Trustee, 123 Apple Lane, Hartford, CT 06006.

Aetna Life Insurance Company
Designation of Beneficiary

Forward to:
Metro Human Resources
Attention: Benefit Services
P.O. Box 198589
Nashville, TN 37219-0589

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

Group Policyholder Name	Group Policy Number	☐ Employee ☐ Retiree	Employee/Retiree Social Security Number
Metropolitan Government of Nashville and Davidson County	**879732**		

Employee/Retiree Name and Address	Coverage(s) this form applies to:
	• Basic Life Insurance • Supplemental Life

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. This Designation of Beneficiary is subject to all "Conditions" shown on the reverse side of this form.

Employee/Retiree Signature	Date

Beneficiary Name and Address	☒ **Primary Beneficiary***	☐ **Basic Life Insurance**	☐ **Supplemental Life Insurance**
Relationship	Social Security Number	Date of Birth (MM/DD/YYYY)	Percentage

Beneficiary Name and Address	☐ **Primary Beneficiary* or**	☐ **Contingent Beneficiary****	☐ **Basic Life Insurance** ☐ **Supplemental Life Insurance**
Relationship	Social Security Number	Date of Birth (MM/DD/YYYY)	Percentage

Beneficiary Name and Address	☐ **Primary Beneficiary* or**	☐ **Contingent Beneficiary****	☐ **Basic Life Insurance** ☐ **Supplemental Life Insurance**
Relationship	Social Security Number	Date of Birth (MM/DD/YYYY)	Percentage

Beneficiary Name and Address	☐ **Primary Beneficiary* or**	☐ **Contingent Beneficiary****	☐ **Basic Life Insurance** ☐ **Supplemental Life Insurance**
Relationship	Social Security Number	Date of Birth (MM/DD/YYYY)	Percentage

*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 1st contingent, 2nd contingent, 3rd contingent, etc. in the order of precedence.
SPOUSAL CONSENT FOR COMMUNITY PROPERTY STATES ONLY**- See Conditions on reverse side of form. **Tennessee is not a community property state and does not require spousal consent.**
***Please note that an employee/retiree is under no obligation to complete the Spousal Consent section of this form.

I am aware that my spouse, the Employee/Retiree named above, has designated someone other than me to be the beneficiary of group life insurance under the above policy. I hereby consent to such designation and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersedes any prior spousal consent or waiver under this plan.

Spouse Signature _____ Date _____

Metropolitan Government

Metro Nashville Human Resources
Annual Enrollment Guide
for 2005 Benefits