



# Application for Membership\*

## Metropolitan Employee Benefit System – Charter School Employees

\*Charter School employees are not eligible to participate in all of the plans comprising the Metropolitan Employee Benefit System. Charter School employees' participation in the Metropolitan Employee Benefit System is limited to certain plans, as provided by Tennessee law.

**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:	
Charter School:		

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

If you are a member of one of these plans other than a 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 an employee of a Charter School, I may participate in certain plans of the Metropolitan Employee Benefit System, subject to the terms and conditions of the plans, which I hereby accept.**

Signature:	Date:
HR Staff Member:	Date:

**Eligibility Date:** \_\_\_\_\_

# Charter School Employee New Employee Benefit Election Form

SSN #

EBS#

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"/> Employee Only <input type="checkbox"/> Employee + Family <input type="checkbox"/> Employee + Child(ren) (no spouse coverage)
Dental Plan	<input type="checkbox"/> Limited PPO <input type="checkbox"/> Flexible <input type="checkbox"/> Opt Out (must provide proof of other coverage)	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Family
Vision Plan	<input type="checkbox"/> Basic <input type="checkbox"/> Enhanced	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Family

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

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

### 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

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	Enroll me with Spouse Coverage of: <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$20,000 If only enrolling dependent children, check \$10,000 box.	<b>Note:</b> If you chose not to enroll now, but enroll your spouse at a later date, he/she 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.
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: _____	

**Acknowledgement** — I attest and affirm that each person named above is related to me by law and is my true legal dependent. 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: \_\_\_\_\_

Are you a veteran or have you ever served in the United States Armed Forces?  Yes  No

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

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

Charter School: \_\_\_\_\_



Metro Nashville

YOU SERVE METRO. WE SERVE YOU.

## 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 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.

\_\_\_\_\_  
Name

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



# Metro Nashville

## Supplemental Insurance Beneficiary Designation/Change

**Forward to:**  
**Metro Human Resources**  
**Attention: Benefit Services**  
**404 James Robertson Pkwy**  
**Suite 1000**  
**Nashville, TN 37219**

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 <b>46767</b>	<input checked="" type="checkbox"/> Employee <input type="checkbox"/> Retiree	Employee/Retiree Social Security Number  Department: <b>CHARTER SCHOOLS</b>
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
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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>
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Relationship	Social Security Number	Date of Birth (MM/DD/YYYY)	Percentage
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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>
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Relationship	Social Security Number	Date of Birth (MM/DD/YYYY)	Percentage
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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>
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Relationship	Social Security Number	Date of Birth (MM/DD/YYYY)	Percentage
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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>
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Relationship	Social Security Number	Date of Birth (MM/DD/YYYY)	Percentage
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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.**

