Certified Employees
email completed form to Kay Harned:
harnedk@wcschools.com

Wilson County Board of Education
415 Harding Dr. Lebanon, TN 37087
Healthcare Enrollment/Change Form
Fax # 615-453-7292 | Group # 14526

Classified Employees
email completed form to Laurie Balfour:
balfourl@wcschools.com

A EMPLOYEE

Employee Name (Last) (First) (MI)	Branch CERTIFIED ☐ CLASSIFIED ☐	Employee ID Number	Date Of Hire	Effective Date

Employee Date of Birth	Social Security Number	Employee Gender Male ☐ Female ☐	Marital Status Married ☐ Single ☐	Home/Cell Phone (with area code)

Address (Street) (City) (State) (Zip Code)

B Enrollment/Change Request (Please Check): Add Employee ☐ Add Dependent ☐ Cancel Employee ☐ Cancel Dependent ☐

Medical Benefit Option			Dental Benefit Option			VSP Vision Benefit Option		
Employee Only ☐	Add ☐	Cancel ☐	Employee Only ☐	Add ☐	Cancel ☐	Employee Only ☐	Add ☐	Cancel ☐
Family ☐	Add ☐	Cancel ☐	Employee + Spouse ☐	Add ☐	Cancel ☐	Employee+1 ☐	Add ☐	Cancel ☐
			Employee+ Children ☐	Add ☐	Cancel ☐	Family ☐	Add ☐	Cancel ☐
			Family ☐	Add ☐	Cancel ☐			

C DEPENDENTS

Names Of Dependents You Wish To Enroll/Change (Last) (First) (M)	Security Security Number	Date of Birth	Gender	Coverage Selection	Add/Cancel
Spouse			M ☐ F ☐	Medical ☐ Dental ☐ Vision ☐	Add ☐ Cancel ☐
Dependent*			M ☐ F ☐	Medical ☐ Dental ☐ Vision ☐	Add ☐ Cancel ☐
Dependent*			M ☐ F ☐	Medical ☐ Dental ☐ Vision ☐	Add ☐ Cancel ☐
Dependent*			M ☐ F ☐	Medical ☐ Dental ☐ Vision ☐	Add ☐ Cancel ☐
Dependent*			M ☐ F ☐	Medical ☐ Dental ☐ Vision ☐	Add ☐ Cancel ☐

*Dependents: Up to age 26 and a dependent of the employee.For additional Dependents or if you or any of your dependents are covered by other insurance at your effective date or anytime thereafter, you must complete the following information. Attach additional forms if needed.

D
OTHER HEALTHCARE COVERAGE - If you or any of your dependents are covered by other insurance at your effective date or anytime thereafter, you must complete the following information. For additional information, complete and attach additional form.

Name of Covered	Social Security Number	Effective Date	Medicare Coverage Part A ☐ Part B ☐ Part D ☐	Medicaid	Other Carrier

Name of Other Employer	Name of other Insurance Company	Address of other Insurance Company

E SIGNATURE - *The information provided above is true and correct to the best of my knowledge, and I accept the provisions below, which I have read and understand.*

Employee's Signature/Date **Employer's Signature / Date**

PROVISIONS: I agree, for myself and my dependents that in the event any heath services provided are the primary responsibility of any other party by way of other group health coverage or by the act or omission of another person, I will fully inform the healthplan and will execute such assignments, liens or other documents that may be necessary to enable the healthplan to recover the value of the services provided. I further agree that in the event I or any of my dependents collect benefits or damages from any other party who has primary responsibility for services provided by the healthplan, I will immediately reimburse the healthplan to the extent of services provided, to the extent permitted by state law. I hereby authorize all doctors, pharmacists, hospitals, or other institutions rendering care and treatment to furnish North America Administrators with information regarding benefits to which I may be entitled. A copy or photocopy of this authorization shall be considered as effective and valid as the original.

FRAUD WARNING: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

AUTHORIZATION TO DEDUCT CONTRIBUTIONS: I authorize deductions (pre-tax, if applicable) from my earnings of the required contributions, if any, toward the cost of the coverage. This authorization applies only if employee contributions are required.