Belmont University
Open Enrollment Election Form
Effective January 1, 2010

EMPLOYEE INFORMATION

Last Name First Name MI	Gender ☐ Male ☐ Female	Date of Birth	Social Security Number

Street	City	State	Zip Code	Home Phone Number	Work Phone Number

TYPE OF COVERAGE

Health: Humana ***(choose one)***

PPO Plan
- ☐ Employee Only
- ☐ Employee + One
- ☐ Family

OR

High Deductible Health Plan
- ☐ Employee Only
- ☐ Employee + One
- ☐ Family

☐ Decline Health Coverage

Dental:
Delta Dental of Tennessee
- ☐ Employee Only
- ☐ Employee + One
- ☐ Employee + Family
- ☐ Decline Dental Coverage

Vision Hardware Reimbursement:
Ameritas
- ☐ Employee Only
- ☐ Employee + One
- ☐ Employee + Family
- ☐ Decline Vision Coverage

COVERAGE INFORMATION

(A) Add (T) Term (C) Chg	Dependent	Last Name	First Name	MI	Social Security Number	Date of Birth (MM/DD/YY)	Gender
	Spouse:						☐ Male ☐ Female
	Child 1:						☐ Male ☐ Female
	Child 2:						☐ Male ☐ Female
	Child 3:						☐ Male ☐ Female
	Child 4:						☐ Male ☐ Female

Authorization

On behalf of myself and anyone enrolled on or added to this form ("Us"), I authorize any health care professional or entity to give Humana and its affiliates (and the employer) or any of their designees, any and all records or information pertaining to medical history or services rendered to Us for any administrative purpose, including evaluation of an application or a claim, and for any analytical or research purposes. I also authorize on behalf of Us the use of a Social Security Number for purpose of identification. I understand and agree that any omissions or incorrect statements made on this application may invalidate my and/or my dependents' coverage. I further understand that coverage will become effective only on the date specified by the Insurer or Plan Administrator after it has been approved by the Insurer or Plan Administrator and after the full premium has been paid. By signing this form, I hereby certify that all the information provided is true and correct. I direct my employer to deduct the amount of any required contribution from my pay.

I understand that if I decline enrollment for my and /or my dependents (including my spouse) because of other health coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 30 days after such coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll my dependents provided that I request enrollment within 30 days after such marriage, birth, adoption, or placement for adoption.

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Signature Date

Please complete the information on the back of this form if you or a family member has coverage through another health plan.

Other Coverage Information (if applicable)		
On the day your coverage begins, will you, your spouse, or any of your dependents be covered under any other health plan or policy including another Humana plan, Medicare or Medicaid?…………………………. ☐ Y ☐ N Is another person legally responsible for coverage for your children?…. ☐ Y ☐ N If you answered yes to either of the questions above, please complete the following:		
Person's Name with Other Health Plan		Social Security Number
Date of Birth	Gender	Other Company's Name and Phone Number:
Other Company's Policy Number and Effective Date		
Medicare Number	Part A Effective Date	Part B Effective Date