TD CONSORTIUM BENEFITS TRUST

Tennessee DENTAL ASSOCIATION

Participant Enrollment/Change Form

Section 1 Employer Information

Group Name/Group #_____

Date of Hire_____Position Title_____Hours Worked per Week _____

Reason for Application:		Employee Type:	
☐ New Group Plan	☐ Termination	☐ Active	☐ Hourly
☐ Life Event/Date _____	☐ New Hire	☐ COBRA	☐ Salary
☐ Status Change	☐ Annual Open Enrollment	☐ State Continuation	☐ Union
☐ Dependent Add/Delete	☐ Late Enrollee	☐ Start Date	☐ Non-Union
☐ Change Name/Address	☐ Change in Coverage	☐ End Date	☐ Retired
☐ Waiving Coverage	☐ Other:_____	☐ Other _____	

Section 2 Employee Information

Name_____
Last *First* *MI*

Address_____City_____State_____ZIP _____

Social Security #_____Date of Birth _____ ☐ Male ☐ Female

Home Phone #_____Cell Phone# _____

Email address _____

Section 3 Family Information

Complete the following information for each dependent (including spouse) to be covered.						
Name (Last, First, MI)	Date of Birth			Relationship (spouse or child)	Gender (M/F)	Social Security Number (Required)
	M	D	Y			

Waiver of Dependent Coverage (if none listed above), for dependents eligible under this plan: I realize that I can include my dependent(s) for consideration within my proposed coverage at this time but have chosen to exclude them. I understand that hereafter I may apply for dependent coverage only during an open enrollment period for my Plan or if a qualifying event occurs as defined in the Plan's Summary Plan Description.

Section 4 Coverage Options and Selection

Medical Plan Options

Check with your Employer for a list of Plans available and make your selection below.

Medical Plan Name		Plan Design Details	
☐ Plan 1-	Classic 500	80% / 20% Co-Ins	$500/$1,000 Deductible
☐ Plan 2-	Classic 1000	80% / 20% Co-Ins	$1,000/$2,000 Deductible
☐ Plan 3-	Classic 2000	80% / 20% Co-Ins	$2,000/$4,000 Deductible
☐ Plan 4-	Classic 3500	70% / 30% Co-Ins	$3,500/$7,000 Deductible
☐ Plan 5-	Classic 5000	70% / 30% Co-Ins	$5,000/$10,000 Deductible
☐ Plan 6-	HSA 5000	80% / 20% Co-Ins	$5,000/$10,000 Deductible
☐ Plan 7-	HSA 6650	100% after Deductible	$6,650/$13,300 Deductible
☐ Plan 8-	Value 7350	100% after Deductible	$7,3500/$14,700 Deductible
☐ Plan 9-	ACO 0	80% after Deductible	$0/$0 Deductible
☐ Plan 10-	ACO 5000	80% after Deductible	$5,000/$10,000 Deductible

*Pharmacy Benefits are integrated with Medical Plans

Pharmacy Plan Options

	Prescription Drugs	Retail / Mail Order
☐ Plan 1	Tier 1-Generic Drugs Tier 2-Preferred Brands Tier 3-Non-Preferred Brands Tier 4-Specialty	$10 Copay / $30 Copay $45 Copay / $90 Copay $85 Copay / $150 Copay Deductible, then 80% coverage
☐ Plan 2	Tier 1-Generic Drugs Tier 2-Preferred Brands Tier 3-Non-Preferred Brands Tier 4-Specialty	$15 Copay / $25 Copay $65 Copay / $87.50 Copay $100 Copay / $162.50 Copay Deductible, then 80% coverage
☐ Plan 3	Tier 1-Generic Drugs Tier 2-Preferred Brands Tier 3-Non-Preferred Brands Tier 4-Specialty	Ded, then $15 Copay / Ded, then $45 Copay Ded, then 80% coverage / Ded, then 80% coverage Ded , then 50% coverage / Ded , then 50% coverage Deductible, then 50% coverage

*Plan 3 is HSA compatible when paired with 5000 HSA or 6650 HSA Medical Plans

Section 5 Termination of Coverage

Termination Effective Date: _____
Note: Coverage remains in effect until the end of the month in which notification is received.

Termination Reason:

- ☐ Voluntary Termination of Employment
- ☐ Involuntary Termination of Employment
- ☐ Reduction in work hours
- ☐ Deceased
- ☐ Divorce or Legal Separation
- ☐ Medicare Entitlement
- ☐ Aged of Plan- Dependent Child who has reached age 26
- ☐ Other _____

I understand that by terminating coverage at this time, I will not be allowed to participate unless I qualify at a special enrollment period, the next enrollment period, or anytime upon a qualifying event as defined in the Plan's Summary Plan Description.

Name:_____ Signature:_____ Date:
Please Print

Section 6 Summary of Benefits and Coverage (SBC)

The Patient Protection and Affordable Care Act has established many new requirements and standards for group health plans, including the requirement to create and distribute a uniform Summary of Benefits and Coverage (SBC). The purpose of the SBC is to provide standard information and uniform language across the health benefits business to allow consumers to easily compare options and select health plans. Members can access SBC's by visiting the Associations' website at www.tndentalassociation.com. A hard copy of the SBC can also be provided upon request. Please call Aetna at 877-362-0871 for a copy or if you have any questions about the SBC's. For more information regarding this healthcare reform provision, please visit www.healthcare.gov.

Section 7 Statement of Contingent Liability

This health coverage is issued by a self-funded multiple employer welfare arrangement. Coverage and benefits provided under a self-funded qualified multiple employer welfare arrangement are not protected by the Tennessee Life and Health Insurance Guaranty Association. If the self-funded qualified multiple employer welfare arrangement does not pay expenses that are eligible for payment under the plan for any reason, the employer or employee covered by the plan will be responsible for the payment of those expenses.

Name: Signature: Date:

_____ _____
Please Print

Section 8 Signature

I understand that I am completing a joint application for coverage and requesting indicated group coverage for myself, and if the plan provides and I (we) have chosen, for my dependent(s). I authorize any required premium contributions to be deducted from earnings or payment for services rendered and owed to me which are considered the employees contribution. Otherwise, failure to remit payment will result in the termination of coverage as outlined in the plan documents. I understand that The Plan or any affiliated organizations are not bound by any statements I have made to any agent, or to any other persons, if those statements are not written or printed on this application and any attachments. I have been informed about : 1) the number, mix and distribution of network providers associated with the plan 2) existence of limitations and disclosures pertaining to my choice of certain healthcare providers, and 3) that The Plan and Affiliated organizations have contracted through a third party to negotiate with certain healthcare facilities to provide these services on a negotiated basis. I further acknowledge that coverage shall become effective only if approved by The Plan Sponsor/Administrator and only for services which are rendered on or after the effective date of coverage. A photocopy of this authorization shall be as effective and valid as the original. Please maintain a copy of this authorization for your records.

By providing my e-mail address, I hereby accept electronic delivery of all plan documents to my e-mail address. Plan documents include but are not limited to Health Care Quality Act, HIPAA Privacy Notice, Medicare Part D Notices, Summary Annual Report, Summary of Benefits and Coverage, Summary Plan Description, and Women's Health and Cancer Rights Act. Occasionally, in addition to electronic communications I may also receive a paper copy document. I understand that I can request a paper copy, free of charge, at any time by calling the plan. I can withdraw from the electronic delivery process at any time in the future by calling the plan. I can opt out of the electronic delivery process at this time by checking the box here: ☐

Name:_____ Signature:_____ Date:

Please Print