

Return Form Directly to:
 Knox County Human Resources
 400 W. Main Street, Suite 360
 Knoxville, TN, 37902
 Fax: 215-2474

Knox County Government Health Enrollment Form Medical, Dental, & Vision 2012

EE# _____

Eff date: _____

PART 1 – EMPLOYEE INFORMATION

Select one: New Hire Qualifying Event

Qualifying events require formal documentation and applicable legal documents attached to this form with date of event, reason for event, & list of all persons(s) affected by change. All changes must be submitted within 30 days of event, and approved by HR.

Last Name	First Name	Middle Name	Date of hire	Social Security Number
Date of birth	Street Address	City	State	Zip
Email Address (list work address as primary)	Elected or Appointed Official	Department	Daytime Phone	Evening Phone

PART 2 – HEALTH PLANS

MEDICAL (CIRCLE ONE BELOW)	DENTAL (CIRCLE ONE BELOW)	VISION THROUGH UNITED (CIRCLE ONE BELOW)
OPTION 1	DELTA DENTAL	YES
OPTION 2	UNITED DENTAL	NO (DECLINE VISION COVERAGE)
OPTION 3		
DECLINE ALL MEDICAL COVERAGE	DECLINE ALL DENTAL COVERAGE	

PART 3 – COVERED MEMBERS – THIS SECTION **MUST** BE COMPLETED FOR YOU AND EACH DEPENDENT YOU WANT TO COVER

	Last Name	First Name	MI	Sex (M/F)	Social Security #	Birth Date	Medical (circle one)	Dental (circle one)	Vision (circle one)
Employee							Yes No	Yes No	Yes No
Spouse							Yes No	Yes No	Yes No
Child							Yes No	Yes No	Yes No
Child							Yes No	Yes No	Yes No
Child							Yes No	Yes No	Yes No
Child							Yes No	Yes No	Yes No

Employee Signature: _____

Date: _____

Rev. 12/06/2011