

# Knox County Retirement & Pension Board

City-County Building, Room 371  
 400 Main Street  
 Knoxville, Tennessee 37902-2401  
 Phone: (865) 215-2323 Fax: (865) 215-2421



## RETIREE ACTIVE MEDICAL INSURANCE

### ENROLLMENT & PAYMENT AUTHORIZATION FORM

2008

#### Part 1 – Employer Use Only (shaded areas)

Group Number	Class/Subgroup	Check One: <input type="checkbox"/> Disability <input type="checkbox"/> Retirement	Check One: <input type="checkbox"/> Normal Ret/Dis. <input type="checkbox"/> Transfer Period <input type="checkbox"/> Safety Officer	Last Date of Active Employment:	Company: KCG	Employee No:
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#### Part 2– Retiree Information

First Name	Last Name	Middle Name	Effective Date:
Social Security Number:		Date of Birth:	Retirement Date:
Street Address			Day Phone: Alternate Phone:
City	State	Zip	County
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female			

#### Part 4– Eligible Participants

##### Important Note:

Please complete the following information for any eligible dependent. Without the proper information your application for medical insurance may be delayed. Your medical insurance will become effective the first day of the month after your last day worked.

Dependent	SSN	Sex	Date of Birth	Relationship

#### Part 3– Plan and Coverage Option

<input type="checkbox"/> Consumer Plan	<u>Single</u>	<u>Plus One</u>	<u>Family</u>	<input type="checkbox"/> Single	
<input type="checkbox"/> Gold Plan	\$404.62	\$818.10	\$968.10	<input type="checkbox"/> Plus One	
<input type="checkbox"/> Silver Plan	\$441.30	\$937.54	\$1,087.54	<input type="checkbox"/> Family	
<input type="checkbox"/> Choice Plan	\$413.44	\$842.98	\$992.98		
	\$446.30	\$957.54	\$1,107.54		

#### Part 4 - Payment Option (Please select ONE of the following payment options)

ACH Debit (deducted from checking or savings account)

**Attach a voided check with this option. Without the voided check your ACH Direct Debit will not go into effect!**

By electing this payment option I hereby authorize Knox County Retirement & Pension Board, to initiate debit entries, if necessary, credit entries and adjustments for debit entries in error, to my  **Checking** or  **Savings account (check one)** to debit and/or credit the same account. This deduction will be made on the 15<sup>th</sup> day of *each* month or the closest business day thereof.

This authority is to remain in effect until the Board receives written notification from me stating otherwise allowing the Board a reasonable opportunity to act on it. *No partial premium deduction is allowed.* **This authority also remains effective with all Medical Insurance Rate Changes.**

**Deduction from Monthly Retirement Check ( Asset Accumulation Plan,  Closed Defined Benefit Plan,  UOPP)**

By electing this payment option I hereby authorize Knox County Retirement & Pension Board to deduct my monthly insurance premium from my monthly retirement check. I understand that my Benefit Payment after taxes must be enough to cover the full insurance premium. No partial premium deduction is allowed. **This authority also remains effective with all Medical Insurance Rate Changes. (Additional form is required, if you are a Public Safety Officer and wish to have Pre-Tax Deductions)**

**Deduction from Medical Expense Retirement Plan (additional form is required for this option).**

By electing this payment option I am authorizing Knox County Retirement & Pension Board to deduct my medical insurance premiums (3) three months at a time after taxes (possibly more due to time of enrollment). Once the balance in my account can no longer pay my premiums in full I will be notified to make another payment selection and if necessary pay any outstanding balances. **This authority also remains effective with all Medical Insurance Rate Changes. (Additional form is required, if you are a Public Safety Officer and wish to have Pre-Tax Deductions)**

**Monthly Invoice. This authority also remains effective with all Medical Insurance Rate Changes.**

#### Part 5– Coverage Information

Do you or any dependent (“insured”) have other health insurance in addition to this plan?  Yes  No

If yes, please give the following information:

Type of Coverage:  Single  Family

Name of Insured: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_

Member I.D. Number: \_\_\_\_\_

#### Part 6 - Signature

Signing below enrolls you and your dependents in the Plan you have selected and authorizes Knox County Retirement to collect premiums based on the option you have chosen.

Signature: \_\_\_\_\_

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