

Mailing Address:

Blount County Government
Human Resources
397 Court St
Maryville TN 37804

Medical and Dental MEMBER CHANGE FORM

Or Fax completed form
to:

Blount County
Human Resources
Department
865-273-5783

PART A – INSURED INFORMATION (Complete in full)		Employee Phone Number:					
Last Name First Middle Initial					Social Security		
Street Address Apartment No.				City		State	Zip
Group Name Blount County Government			Department/School			Effective Date of Change	
PART B – CHANGE INFORMATION (Check [] appropriate change[s].)							
		Change From			Change To		
<input type="radio"/> Name	Last Name First Middle Initial			Last Name First Middle Initial			
<input type="radio"/> Address	Street Address Apartment No.			Street Address Apartment No.			
	City	State	Zip	City	State	Zip	
<input type="radio"/> Phone	Home: ()			Home: ()			
	Work: ()			Work: ()			
<input type="radio"/> Addition of Dependent(s) (Attach adoption papers, marriage or birth certificate, etc.)		Does dependent(s) have other coverage? Yes No					
		If yes, name of insurance carrier:					
	Last Name First Middle Initial	Social Security Number	Date of Birth	Sex	Relationship to Insured	Medical or Dental or Both	Reason for Addition (marriage, birth, adoption, etc.)
<input type="radio"/> Removal of Dependent(s) (State reason for removal, i.e., divorce, death, over age child, marriage of child, etc. attach documents)							
	Last Name First Middle Initial	Social Security Number	Date of Birth	Sex	Relationship to Insured	Medical or Dental or Both	Reason for Removal
PART C – SIGNATURE (This form must be signed and dated before it can be processed.)							
I hereby apply for amendment of my health plan application. It is mutually agreed that (1) these changes will not become effective unless and until this change form is signed and accepted, and (2) this application for change in coverage will become a part of my original health plan application and will be subject to the terms of the agreement in effect with my employer and/or TPA Services. If a change in health plan premium is required as a result of the changes requested herein, I agree to have my employer deduct the changed premium from my wage or salary. Monthly dependent premiums for medical \$100.00 and for dependent dental \$44.00 until further notice.							
Authorized Signature					Date		