

CITY OF FRANKLIN, TN MEDICAL ENROLLMENT/CHANGE FORM

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SOCIAL SECURITY NUMBER

GROUP NUMBER: 111164 GROUP NAME: City of Franklin, TN

EFFECTIVE:

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FIRST NAME	MI	LAST NAME
STREET ADDRESS		
CITY	STATE	ZIP
HOME PHONE		WORK PHONE

THIS IS A CHANGE OF ADDRESS OR PHONE NUMBER

DATE OF BIRTH	DATE OF HIRE	GENDER	MARITAL STATUS
		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCE

Are you enrolling your spouse and/or dependents in this plan? YES NO

FIRST, MI (LAST NAME IF DIFFERENT)	GENDER		BIRTH DATE			
	M	F				
SPOUSE:						
DEPENDENT:						
DEPENDENT:						
DEPENDENT:						
DEPENDENT:						
DEPENDENT:						

I agree to make the required contribution. I certify that the information contained in this form is true and correct to the best of my ability.

Signature: _____ Date: _____

DECLINATION OF COVERAGE I have been given the opportunity to apply for group medical insurance coverage through the City of Franklin, TN and choose at this time to not take coverage. I understand that by signing this area I am declining this coverage because: <input type="checkbox"/> I have other medical coverage <input type="checkbox"/> I do not want at this time <input type="checkbox"/> other: _____ Declination Signature: _____ Date: _____
