

**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 DENTAL INSURANCE ENROLLMENT / CHANGE FORM**

**OPEN ENROLLMENT 2017**

Employee #: \_\_\_\_\_

**Part 1 – Enrollment Information**

Group No: 115650	<u>Check One:</u> <input type="checkbox"/> Retirement <input type="checkbox"/> Disability	<u>Check One:</u> <input type="checkbox"/> KCG <input type="checkbox"/> E-911 <input type="checkbox"/> KCS <input type="checkbox"/> UOPP	Retirement Date: _____ Last Work Day: _____ Last Pay Day: _____ Insurance Ends: _____	<u>Check One:</u> <input type="checkbox"/> Enroll <input type="checkbox"/> Change <input type="checkbox"/> Pmt. Change	<u>Effective Date:</u> _____
DentalBlue					

**Part 2 – Retiree Information**

Name: _____		<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number: _____
Street Address: _____		Date of Birth: _____	Day Phone: _____
City: _____	State: _____	Zip: _____	County: _____

**Part 3 – Eligible Participants**

**Important Note:** Please complete the following information for any eligible dependent. Without the proper information your application for dental insurance may be delayed.

—————> Do you currently have Dental Coverage through KCG or KCS?  Yes  No <—————

Spouse/Dependent	SSN	Gender	Date of Birth	Relationship

**Part 4 – Coverage Option and Monthly Rates**

Individual \$29.79       Retiree plus One \$59.50       Family \$93.89

**Part 5 – Payment Option (Please select ONE of the following payment options)**

1.  **ACH Debit (deducted from checking or savings account) - Attach a voided check with this option.**

Financial Institution: _____	Type of Account: <input type="checkbox"/> Checking <input type="checkbox"/> Savings
Routing Number (Must be 9 digits): _____	Account Number: _____

2.  **Deduction from :**  Asset Accumulation Plan  Defined Benefit Plan  UOPP  Disability

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

**Please Read Important information**

**Payment Option 1.** By electing this payment option I hereby authorize Knox County Retirement & Pension Board to initiate debit entries and adjustments to my checking or savings account. This deduction will be made on the 5<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.*

**Payment Option 2.** 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.*

**Payment Option 3.** By electing this payment option I am authorizing Knox County Retirement & Pension Board to deduct my dental insurance premiums (3) three months at a time after taxes (possibly more due to time of enrollment) from my Medical Expense Retirement Plan. 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. **Additional form is required.**

Your payment option remains effective with all Dental insurance rate changes

**Part 6 – Coverage Information**

Do you or any dependent (“insured”) have other dental insurance in addition to this plan?  Yes  No  
 If yes, please give the following information:

Type of Coverage:  Single  Family  
 Name of Insured: \_\_\_\_\_ Policy #: \_\_\_\_\_  
 Insurance Carrier: \_\_\_\_\_ Member I.D. #: \_\_\_\_\_

**Part 7 – 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: \_\_\_\_\_