NEW=HIRE=PAPERWORK

Application for Membership Metropolitan Employee Benefit System

INSTRUCTIONS: Please complete these forms and return them to the MNPS Employee Benefits Department. For more information, call (615) 259-8462 or email <u>Benefits@mnps.org</u>.

PART 1 – About You							
Name:		EMP ID#:					
Date of Birth: Date Employed:							
Metro Department:							
PART 2 – About Your Employment							
Please check any plans of which you are currently a member, receiving benefits from or have a vested pension benefit due: The Metro Plan Old City Plan Old County Plan Electric Power Board Plan (NES) * Any retirement plan for Teachers * If you are a member of one of these plans other than the Metro Plan, you are not eligible to be member of the Metro Benefit System. *Service with these plans cannot be connected to your Metro service.							
Have you previously been employed by Metropolitan Govern	ment?						
Which Department?							
Dates of Employment							
PART 3 – Acknowledgement							
I understand that as a condition of my employment I sha Benefit System, the terms and conditions of which I here		te as a member of the Metropolitan Employee					
Signature:		Date:					
HR Staff Member:		Date:					

Eligibility Date:

Metro Human Reso	ources				EMP I	D#
New Employ	vee Bei	nefit Elec	tion Fo	rm	Ins eff	Date
Benefit		check one p			с	heck one per benefit
Medical Plan	PPO Pla Opt Out	_	HRA Plan ust provide proof of other coverage)		Employee Only Employee + Family Employee + Child(ren) (no spouse covera	
Dental Plan	Limited	PPO Flexible)	Employee	
Vision Plan	Basic	Enhand	ced		Employee	-
Are you covered as a dep Name:	pendent on th	e insurance of anot	ther Metro empl Depart		ouse or parent)? If	f yes, complete information.
Dependent Informa	tion — List	all dependents y	ou want to cov	ver.		
Name		SSN	Spouse / Child	Male / Female	Birth Date	Desired Coverage
Supplemental Life Dependent Life Short-Term Disability	Note: If you Enroll me v □ \$10,000 □ \$5,000 □ Enroll me	chose not to enroll no vith Spouse Covera)	age of:	later date, No at Ins No da	you will be subject to ote: If you chose not a later date, he/she surability. ote: If you chose not te, a late-enrollment	
Long-Term Disability	Enroll m	ie			ote: If you chose not te, a late-enrollment	to enroll now, but enroll at a later penalty may apply.
Flexible Spending Accounts (FSAs)			Ar	Dependent Care FSA Annual election amount \$		
Before-Tax Premium Savings Plan	If you elect insurance, you are automatically enrolled in the before-tax premium savings plan which sav you tax dollars on the cost of your health insurance premiums. If you do NOT wish to participate in t program, please initial here:					
	of my annual	taxable salary base	ed on my electi	ons above	e. I understand th	and is my true legal dependent. hat my elections will remain in effe e change in status. Date:

	······································	Date:		
Print Employee Name:	SS#:	DOB:		
Are you a veteran or have you ever served in the United States Arr	ned Forces? 🗌 Yes 🗌 No			
Home Phone Number:	Work Phone Number:			
Address:	City:	State:	Zip:	
Department:				_



Eligible Spouse/Dependent Certification Form

Instructions: To cover your Spouse and/or Dependent Child(ren) on Metro's insurance plans, you must confirm their eligibility. Please complete this Certification Form by indicating whether your Spouse and/or Dependent Child(ren) meet the following criteria.

Qualification of Marital Status

Spouse's Name:

- I am legally married to my spouse named above and we are NOT divorced, legally separated or common-law married.
- My spouse is NOT on active duty in the armed forces of any country or international organization, or a member of a civilian force auxillary to any military force.

Qualification of Dependent Child Status

Dependent Children's Names:

The dependent child(ren) listed above meet the following criteria and each child:

- Is my child by birth; legal adoption or has been placed with me for adoption; is my stepchild whose primary residence is with me and my spouse, is my child by legal guardianship, court order or Qualified Medical Child Support Order (QMCSO);
- Is UNDER the age of 26;
- Is NOT on active duty in the armed forces of any country or international organization, or a member of a civilian force auxillary to any military force.

Signature

I certify the information I have provided is true and correct and that I am responsible for updating this information in the event it changes. I understand the information will be reviewed and a determination will be made regarding my dependent's eligibility for coverage. I acknowledge that falsifying this information or failing to update this information can lead to cancellation of my dependent's coverage and disciplinary action up to and including termination of employment. Submission of this form does not guarantee eligibility for benefits.

Date:

Name

Updated 11/2/13



Metropolitan Government of Nashville and Davidson County

Life Insurance Beneficiary Designation

Basic Life and Supplemental Life - Group Policy #46767

Return form to Metro Human Resources by: fax: (615) 862-6713 email: HRBenefitServices@nashville.gov mail: 700 President Ronald Reagan Way, Suite 201 Nashville, TN 37210

Refer to the instructions on the reverse side before completing this form.

1.EMPLOYEE / PENSIONER INFORMATION (please print)

First Name MI Last Name	Employee Pensioner
	Department:
Address City State Zip	Employee ID# or Social Security#
Liniass otherwise indicated below, this Beneficiary Designation form applies to ALL coverages offered	under Metro's group life insurance plan. This form

Unless otherwise indicated below, this Beneficiary Designation form applies to ALL coverages offered under Metro's group life insurance plan. This form applies only to: Basic Life Supplemental Life

2.BENEFICIARY DESIGNATION: I hereby revoke any previous beneficiary designations and in the event of my death, designate the following:

Α.	Primary	Beneficiaries	

First Name, MI, Last Name	Address (include city, state, zip)	Relationship	Date of Birth	Phone Number	% Share
		I	TO.	L FAL (must equal 100%)	

B. Contingent Beneficiaries

First Name, MI, Last Name	Address (include city, state, zip)	Relationship	Date of Birth	Phone Number	% Share
			TO	TAL (must equal 100%)	

3.TRUST DESIGNATION - Complete if a Trust has been named as a beneficiary in Section 2.

Trustee's Name (First, MI, Last)	Address (include city, state, zip)	
And successor(s) in trust, as Trustee(s) under		(Title of Agreement)

dated _____ (Date of Agreement) as amended and executed by me and said Trustee.

AUTHORIZATION and SIGNATURE

By my signature below, I authorize Metro Nashville Government to record the beneficiaries I have named on this form for benefits under the life insurance benefit plans and I understand this designation revokes all previous designations.

Employee / Pensioner Signature X_____ Date Signed:

INSTRUCTIONS FOR COMPLETING METRO'S LIFE INSURANCE BENEFICIARY DESIGNATION FORM

INSTRUCTIONS:

- 1. All Employee/Pensioner information is required in Section 1.
- Please indicate whether this designation applies to your basic life insurance benefits, supplemental life insurance benefits (if applicable) or both. Unless otherwise indicated, all information supplied on this form will apply to ALL coverages offered under Metro's group life insurance plan.
- In Section 2, list the primary and contingent beneficiary(ies) full name, address, relationship, phone number and indicate the percentage share designated to each type of beneficiary (see information below to assist in naming and completing this form).
- 4. The percentage total for all primary beneficiaries must add up to 100% and the total for contingent beneficiaries (if named) must also add up to 100%. If you need additional space to list additional primary or contingent beneficiaries, please attach a separate sheet of paper and mark them as primary or contingent and include their percentage share.
- 5. You can name an individual, estate, trust or corporation/organization as a beneficiary. If you designate a Trust, you must also complete Section 3 to include the name and address for each trustee and the date of the Trust Agreement.
- 6. Read the authorization and sign the form.
- 7. Return the form to Metro Human Resources.

The following definitions and examples may be helpful in designating your beneficiaries:

Primary Beneficiary(ies) – the person(s) or entity you choose to receive your life insurance proceeds. You may name more than one primary beneficiary. Payment will be made in equal shares unless otherwise specified by noting the percentage share on the beneficiary designation form. In the event that a designated primary beneficiary predeceases you, the proceeds will be paid to the remaining primary beneficiaries in equal shares or all to the sole remaining primary beneficiary.

Contingent Beneficiary(ies) – the person(s) or entity you choose to receive your life insurance proceeds if the primary beneficiary(ies) die (or the entity dissolves) before you die. You may name more than one contingent beneficiary. Payment will be made in equal shares unless otherwise specified by noting the percentage share on the beneficiary designation form. If a designated contingent beneficiary predeceases you, the proceeds will be paid to the remaining contingent beneficiaries in equal shares or all to the sole remaining contingent beneficiary. If there are no beneficiaries remaining, the benefits will be paid in accordance with the insured group contract.

Individual: "Mary A. Doe"

- Each beneficiary should be listed as first name, middle initial, last name ("Mary A. Doe," not "Mrs. M. Doe")
- Include the address, relationship, date of birth and phone number for each individual listed.
- Indicate the percentage to be assigned to each individual.

Estate: "Estate of the Insured"

- Write "Estate of Insured" in the space for the Beneficiary's name.
- Indicate the percentage to be assigned to your Estate.

Corporation/Organization: "ABC Charitable Organization"

- Write the legal name of the corporation or organization in the space for the Beneficiary's name.
- Include the address, city and state, telephone number and tax ID number of operation for each organization or corporation listed.
- Indicate the percentage to be assigned to the corporation or organization.

Trust: "The John Doe Trust. A Trust with a trust agreement dated 1/1/22 whose Trustee is Jane Smith."

- Write the legal name of the "Trust" in the space for Beneficiary's name.
- Indicate the percentage to be assigned to the trust.
- Complete Section 3, Trust Designation.

DESIGNATION OF BENEFICIARY - \$500 DEATH BENEFIT

As Provided by Metropolitan Charter, Article 9, Section 9.03

In accordance with provisions of the Charter of Metropolitan Government, Metropolitan Nashville Public Schools provides a benefit of \$500 payable at the time of death of an employee or retiree.

Named Beneficiary for \$500 Death Benefit:

	1	Name(Last, First M.I.):	3	Name(Last, First M.I.):	
		Street Address, City, Sta	te, Zip	Street Address, City, State, Zip	
		Relationship to you.		Relationship to you.	
		Social Security #		Social Security #	
		Date of Birth		Date of Birth	
		Designation Code:		Designation Code:	
	2	Name(Last, First M.I.):	2	Name(Last, First M.I.):	
		Street Address, City, Sta	to Zin	Street Address, City, State, Zip	
		Street Address, City, Sta	τε, 2ιρ	Street Address, city, State, Zip	
		Relationship to you.		Relationship to you.	
		Social Security #		Social Security #	
		Date of Birth		Date of Birth	
		Designation Code:		Designation Code:	
Design	Designation Codes: A=Single Beneficiary			D=1 st (Primary) NOTE: If beneficiary is un	
		B=Equal S C=Upequa	Shares al Shares (specify %)	E=2 nd (contingent) age 18 there must F=Trustee be a Trustee name	
		0–0fiequa	an onlares (speenly 70)		<i>.</i>

I understand that I may change my beneficiary at any time and that any change must be in writing. I hereby revoke all beneficiaries previously designated by me and name the above individual(s) as my true and correct beneficiary(ies) as of this date.

Employee Signature: _____ Date: _____

Received	and	Acknow	ledged
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Date:

Beneficiary Designation Form [Tenn. Code Ann. § 30-2-103]

Unpaid Active Compensation for Deceased Employee

PART 1 – Beneficiary Designation Options								
This is to designate the beneficiary or beneficiaries named below to receive any unpaid compensation related to my Metro employment due and payable at the time of my death. In the event that more than one beneficiary is listed below, the amount payable will be equally split among the named beneficiaries.								
PART 2 – About You								
Employee Name:			SSN:		DOB:			
Street:								
City:		State:		Zip:				
Metro Department:								
PART 3 – Beneficiary Designation	on (complete for ea	ach benef	iciary)					
Name:			SSN:					
Street:				1				
City:	1	State:		Zip:				
Date of Birth:	Relationship to you:							
Name:			SSN:					
Street:				1				
City:	1	State:		Zip:				
Date of Birth:	Relationship to you:							
Name:			SSN:					
Street:		ſ		1				
City:	1	State:		Zip:				
Date of Birth:	Relationship to you:							
Name:			SSN:					
Street:		ſ		1				
City:	1	State:		Zip:				
Date of Birth:	Relationship to you:							
PART 4 – Acknowledgement								
I understand that my signature below is acknowledgment that this document replaces any previous beneficiaries designated to receive any unpaid wages or salary related to my employment due at the time of my death. I hereby designate the above-named individual(s) as my true and correct beneficiary(ies) as of this date.								
Signature:				Date:				
Witness				Date:				

Updated 10/20/21



INSURANCE OPT OUT ELECTION – FOR METRO EMPLOYEES AND DISABILITY PENSIONERS

As a Metro Employee working 20 or more hours per week or a Disability Pensioner, the Metro Code requires you to be covered under Metro's medical and dental coverage unless you have proof of other non-Medicare insurance coverage (which may not include Medicare Advantage plans, Medicare Supplement plans, or Medicare A, B and/or D itself). If your spouse, domestic partner or parent works for Metro, you may elect to be covered as a dependent on his/her medical and/or dental plan (you may only be covered on a parent's plan up to age 26, at which point you will be required to enroll in your own Metro coverage). If you and your spouse/domestic partner do not have dependent children, it will be cheaper to have two separate Single coverage plans.

You may opt out of Metro coverage at Annual Enrollment or within 60 days of an Eligible Change in Status with proof of other non-Medicare coverage. If you lose your other insurance coverage, you must notify Metro Human Resources and enroll in Metro coverage within 60 days.

ACKNOWLEDGEMENT: I understand that I am under an obligation to provide written documentation to Metro Human Resources within 60 calendar days of losing my other medical and/or dental coverage and that I must enroll in Metro's coverage within 60 calendar days. I understand that if I do not enroll at the time of an Eligible Change in Status, I may not enroll until the next Annual Enrollment. I further understand that if I fail to notify Metro Human Resources and do not enroll during this 60 calendar day period, I am violating the terms and conditions of my employment and exposing myself to considerable financial risk.

I elect to Opt Out of Metro's coverage as checked here: **MEDICAL DENTAL** My other coverage was was not obtained through the Affordable Care Act's Marketplace Exchange.

My Spouse/Domestic Partner/Parent also works for Metro, and I am electing to be covered as a dependent on his/her MEDICAL and/or DENTAL plan(s). Your spouse/domestic partner/parent must immediately contact Metro Human Resources to add you as a dependent to their plan.

Employee Printed Name

SSN or Employee #

Department

Employee Signature

Date:

Spouse/Domestic Partner/Parent's Printed Name Spouse/Domestic Partner/Parent's Department

Metro HR Representative

Date:

Opt Out Effective Date

