NEW=HIRE=PAPERWORK

Application for Membership
Metropolitan Employee Benefit System

INSTRUCTIONS: Complete this form and bring it with you to the New Employee Orientation. For more information, call Metro Human Resources at (615) 862-6700.

PART 1 – About You	
Name:	SSN:
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 Government?
☐ No☐ Yes

Which Department? _____

Dates of Employment _____

PART 3 – Acknowledgement	
I understand that as a condition of my employment I shall participate as a member of the Metropolitan Employee Benefit System, the terms and conditions of which I hereby accept.	
Signature:	Date:
HR Staff Member:	Date:
Eligibility Date:	

Metro Human Resources **SSN #** **EBS#**

New Employee Benefit Election Form

Ins eff Date

Benefit	check one per benefit	check one per benefit
Medical Plan	☐ PPO Plan ☐ HRA Choice Fund ☐ Opt Out (must provide proof of other coverage)	☐ Single ☐ Family ☐ Employee + Child(ren)
Dental Plan	☐ Limited PPO ☐ Flexible ☐ Opt Out (must provide proof of other coverage)	☐ Single ☐ Family
Vision Plan	☐ Basic ☐ Enhanced	☐ Single ☐ Family

Are you covered as a dependent on the insurance of another Metro employee (spouse or parent)? If yes, complete information.

Name:_____ Department:_____

Dependent Information — List all dependents you want to cover.

Name	SSN	Spouse / Child	Male / Female	Birth Date	Desired Coverage
					☐ Medical ☐ Dental ☐ Vision
					☐ Medical ☐ Dental ☐ Vision
					☐ Medical ☐ Dental ☐ Vision
					☐ Medical ☐ Dental ☐ Vision
					☐ Medical ☐ Dental ☐ Vision
					☐ Medical ☐ Dental ☐ Vision
					☐ Medical ☐ Dental ☐ Vision
					☐ Medical ☐ Dental ☐ Vision

Supplemental Life	☐ Enroll me in the amount of $_____ (multiples of $10,000 up to a maximum of $200,000) **Note**: If you chose not to enroll now, but enroll at a later date, you will be subject to Evidence of Insurability.	
Dependent Life	Enroll me with Spouse Coverage of: ☐ $10,000 ☐ $20,000 ☐ $5,000 (enrolling dependent children only)	**Note**: If you chose not to enroll now, but enroll your spouse at a later date, he/she will be subject to Evidence of Insurability.
Short-Term Disability	☐ Enroll me	**Note**: If you chose not to enroll now, but enroll at a later date, a late-enrollment penalty may apply.
Long-Term Disability	☐ Enroll me	**Note**: If you chose not to enroll now, but enroll at a later date, a late-enrollment penalty may apply.
Flexible Spending Accounts (FSAs)	**Health Care FSA** Annual election amount $_____	**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 saves you tax dollars on the cost of your health insurance premiums. If you **do NOT wish to participate** in this program, please initial here: _____	

Acknowledgement — I attest and affirm that each person named above is related to me by law and is my true legal dependent. I authorize the adjustment of my annual taxable salary based on my elections above. I understand that my elections will remain in effect from my insurance effective date through the remainder of the plan year unless I experience an eligible change in status.

Employee Signature: _____ Date:_____

Print Employee Name: _____ SS#:_____ DOB:_____

Are you a veteran or have you ever served in the United States Armed Forces? ☐ Yes ☐ No

Home Phone Number: _____ Work Phone Number: _____

Address:_____ City:_____ State:_____ Zip:_____

Department: _____

SSN # «SSN» EBS# «EBS»

Metro Nashville

YOU SERVE METRO. WE SERVE YOU.

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

DESIGNATION OF BENEFICIARY - $500 DEATH BENEFIT

As Provided by Metropolitan Charter, Article 9, Section 9.03

EMPLOYEE NAME: _____ Social Security Number: _____

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, State, 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.):	4	Name(Last, First M.I.):
	Street Address, City, State, 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:

Designation Codes: A=Single Beneficiary
B=Equal Shares
C=Unequal Shares (specify %)
D=1st (Primary)
E=2nd (contingent)
F=Trustee

NOTE: If beneficiary is under age 18 there must also be a Trustee named.

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 Acknowledged:

By: _____ **Date:** _____

Metro Nashville

Life Insurance Beneficiary Designation/Change

Forward to:
Metro Human Resources
Attention: Benefit Services
404 James Robertson Pkwy
Suite 1000
Nashville, TN 37219

Before executing this form refer to the other side. Please keep a copy for your records.

Group Policyholder Name **Metropolitan Government of Nashville and Davidson County**	Group Policy Number **46767**	☒ Employee ☐ Retiree	Employee/Retiree Social Security Number Department:

Employee/Retiree Name and Address	Coverage(s) this form applies to: • Basic Life Insurance • Supplemental Life

Subject to the terms of the above numbered Group Policy(ies), I request that any sum becoming payable by reason of my death be payable to the following beneficiary(ies). It is my understanding that this designation shall operate so as to revoke all designations of beneficiary and all election of optional methods of settlement previously made by me under said Policy(ies). If this Designation of Beneficiary refers only to a Group Life Insurance Policy and if I am also insured for Supplemental and/or Group Accidental Death coverage, this designation shall apply to those coverages.

Employee/Retiree Signature	Date

Beneficiary Name and Address ☒ **Primary Beneficiary*** ☐ **Basic Life Insurance** ☐ **Supplemental Life Insurance**

Relationship	Social Security Number	Date of Birth (MM/DD/YYYY)	Percentage

Beneficiary Name and Address ☐ **Primary Beneficiary*** or ☐ **Contingent Beneficiary**** ☐ **Basic Life Insurance** ☐ **Supplemental Life Insurance**

Relationship	Social Security Number	Date of Birth (MM/DD/YYYY)	Percentage

Beneficiary Name and Address ☐ **Primary Beneficiary*** or ☐ **Contingent Beneficiary**** ☐ **Basic Life Insurance** ☐ **Supplemental Life Insurance**

Relationship	Social Security Number	Date of Birth (MM/DD/YYYY)	Percentage

Beneficiary Name and Address ☐ **Primary Beneficiary*** or ☐ **Contingent Beneficiary**** ☐ **Basic Life Insurance** ☐ **Supplemental Life Insurance**

Relationship	Social Security Number	Date of Birth (MM/DD/YYYY)	Percentage

If a Trust has been named as a beneficiary above, please complete the following:

Trustee's Full Name:____

Trustee's Address:____

Title of Trust Agreement:______________________________ Date of Agreement:__________

***If more than one Primary Beneficiary is named, the Primary Beneficiaries shall share equally unless otherwise indicated above.**

**Contingent Beneficiary(ies) will only receive proceeds if all Primary Beneficiaries have predeceased the Insured. If you are naming more than one Contingent Beneficiary at 100% each, please indicate 1st contingent, 2nd contingent, 3rd contingent, etc. in the order of precedence.

BENEFICIARIES

Revised 11/1/09

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 (complete for each beneficiary)		
Name:	SSN:	
Street:		
City:	State:	Zip:
Date of Birth:	Relationship to you:	
Name:	SSN:	
Street:		
City:	State:	Zip:
Date of Birth:	Relationship to you:	
Name:	SSN:	
Street:		
City:	State:	Zip:
Date of Birth:	Relationship to you:	
Name:	SSN:	
Street:		
City:	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	
_____	Date: _____	_____
Metro HR Representative		Opt Out Effective Date