TENNESSEE SCHOOLS

To elect the voluntary Gap Medical benefit for the Partnership PPO or the Standard PPO plans, follow these steps:

- ✓ Complete the enclosed enrollment form for the Beazley Group Supplemental Out-of-Pocket Medical Expense Insurance Policy
- ✓ Fill out all blank sections
- ✓ Sign and date (on back side)
- ✓ Hand-deliver or mail your completed enrollment form to your Benefits Department.

If you have questions, call (800)435-5023, extension 1.

Beazley Insurance Company, Inc.
Administrative Office
c/o HealthPlan Services, Inc.
PO Box 30236
Tampa, FL 33630-3236

Group Supplemental Out-of-Pocket Medical Expense Insurance Policy ENROLLMENT FORM

ENROLLEE INFORMATION

Last Name	First Name	M.I.	Social Security #	Date of Birth

Street Address	Apt. No.	City	State	Zip Code

Home Phone: ( )	Work Phone: ( )	Gender ☐ M ☐ F	Marital Status ☐ Single ☐ Married

Employer Name:	Job Title	Division	Date of Employment

Insurance Requested:
☐New Enrollment ☐ Status Change: (Family status / Address / Name / Other) Date of Change: N/A

Are you currently Actively at Work and able to perform the duties of your occupation? ☐ Yes ☐ No If No, are you an early retiree? ☐ Yes ☐ No If yes, please provide your date of retirement: _____	How many hours are you regularly working per week with your current employer? _____ Hours per week Not applicable to early retirees.

Coverage Election: Please select coverage for you and your Spouse and/or Child(ren), if applicable.

☐ Enrollee Only ☐ Enrollee Plus Spouse[/Domestic Partner] ☐ Enrollee Plus Child(ren) ☐ Enrollee Plus Family

DEPENDENT INFORMATION *(Complete only for Dependents to be covered under this plan)*

Last Name	First Name	M.I.	Relationship	Date of Birth	Gender
					☐ M ☐ F
					☐ M ☐ F
					☐ M ☐ F
					☐ M ☐ F

Current Coverage

1. Are all proposed insureds, including dependents, currently covered by the group policyholder's major medical insurance plan?
   ☐ Yes ☐ No
   If No, list each individual who is not covered; coverage will not be provided for individuals who do not have major medical coverage.
   _____
2. Are any proposed insureds, including dependents, who are applying for coverage covered by Medicaid, Medicare, CHAMPUS, or TRICARE? ☐ Yes ☐ No

   If Yes, list each individual; coverage will not be provided for individuals covered under any one of these programs.
   _____

SIGNATURE *(This form must be signed)*

AUTHORIZATION AND ACKNOWLEDGMENT

I hereby declare that all the statements made above and on the reverse side are, to the best of my knowledge and belief, true and complete and that I understand they are the basis on which insurance requested by me may be issued.

All statements made by me are representations and not warranties. No statement made by me will be used to contest the insurance provided by the Policy, unless: 1) it is contained in a written statement signed by me; and 2) a copy of the statement is furnished to me. I agree that a photocopy of this form shall be as valid as the original, and that it shall be valid for 24 months from the date signed. I also understand that I, or the person authorized to act on my behalf, is entitled to receive a copy of this authorization form.

I understand that by signing this form I am authorizing the necessary premium deductions from my salary or wages or pension for the coverage I have selected.

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

I, the Proposed Insured, hereby attest that I currently have other health coverage in force that qualifies as minimum essential coverage as defined by Section 5000A(f) of the Internal Revenue Code. ☐ Yes ☐ No I understand that by checking "no", this insurance will not be issued.

AUTHORIZATION AND ACKNOWLEDGMENT - I certify that the above information is true and correct to the best of my knowledge and belief.

Please continue to read below for special notices required by state law.

X _____ _____

Signature of Proposed Insured Date Signed

FRAUD WARNING

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.