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 Benefits@mnps.org.

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 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 **EMP ID#**

New Employee Benefit Election Form

Ins eff Date

Benefit	check one per benefit	check one per benefit
Medical Plan	☐ PPO Plan ☐ HRA Plan ☐ Opt Out (must provide proof of other coverage)	☐ Employee Only ☐ Employee + Family ☐ Employee + Child(ren) (no spouse coverage)
Dental Plan	☐ Limited PPO ☐ Flexible ☐ Opt Out (must provide proof of other coverage)	☐ Employee Only ☐ Employee + Family
Vision Plan	☐ Basic ☐ Enhanced	☐ Employee Only ☐ Employee + 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 in the amount of $_____ (multiples of $10,000 up to a maximum of $500,000)	**Note**: If you chose not to enroll now at the guaranteed issue amount of $400,000 but enroll at a later date, you will be subject to Evidence of Insurability.
Dependent Life	☐ Enroll with Spouse Coverage of $_____ (multiples of $10,000 up to a maximum of $50,000) ☐ $5,000 (enrolling dependent children only)	**Note**: If you chose not to enroll now at the guaranteed issue amount of $20,000 but enroll your spouse at a later date, he/she will be subject to Evidence of Insurability.
Short-Term Disability	☐ Enroll	**Note**: If you chose not to enroll now, but enroll at a later date, a late-enrollment penalty may apply.
Long-Term Disability	☐ Enroll	**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: _____

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

Metropolitan Government of Nashville and Davidson County
Life Insurance Beneficiary Designation

Basic Life and Supplemental Life

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#
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:

A. Primary Beneficiaries

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

B. Contingent Beneficiaries

First Name, MI, Last Name	Address (include city, state, zip)	Relationship	Date of Birth	Phone Number	% Share
				TOTAL (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.
2. 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.
3. 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.