



## *New Hire Enrollment Guide*



***IMPORTANT NOTICE:*** As a new hire of Tony's Foodland you may be eligible to enroll in certain insurance benefits. If you don't enroll in eligible benefits when first offered, you will have to wait until Annual Enrollment (In October each year for a November 1 effective date) to enroll unless you experience a qualifying event/change in status (birth, marriage, divorce, etc.). Please make sure you sign applicable enrollment forms or waivers.

***NOTE:*** *If there is a discrepancy between the information shown in this summary and information shown in the master contract, the provisions of the master contract will govern.*

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## Welcome to your New Hire Enrollment Guide

The purpose of the New Hire Enrollment Guide is to acquaint you with the benefits Tony's Foodland offers and to serve as a reference source throughout the year.

If you want to **enroll** in the Medical, HSA and Pre-Tax plans please complete the appropriate forms.

If you wish to **waive** participation in any of the plans, please complete the waiver section of the corresponding form.

- If you wish to enroll in the AFLAC Accident, Cancer, Short-Term Disability and Life insurance plans please call Kandi Heckler at AFLAC. See page 7 for more details and her contact information.
- Voluntary Health Savings Accounts (HSA) and Pre-Tax Programs are offered.
- If you enroll in the Blue Cross Medical or HSA Bank plans, your card will be mailed to your home address on file.
- Enrollment in any of the benefit plans is not automatic. You must complete forms, give them to Tony Hunter and be approved in order to be enrolled.

## How Tony's Foodland Benefits Work

- Comprehensive PPO Medical Plan, Blue Cross Blue Shield of Tennessee, Network "S" is available.
- New Hire Enrollment in Medical, HSA, Cafeteria and Voluntary AFLAC plans.
- New Hire and Annual Enrollment are the only times you may make elections and/or changes unless you have a qualifying event (birth, marriage, divorce, etc.).
- Changes made because of qualifying event/change in status (birth, marriage, etc.) must be made within 31 days of the qualifying event/change in status or you will have to wait until annual enrollment to make changes, add/delete dependents, etc. Contact Tony Hunter as soon as a qualifying event/change in status occurs.
- Telemedicine through PhysicianNow/MDLive phone app now available. See page 5 for more information.

### Paying For Your Medical Coverage

Medical plan rates are based on age. Please see Tony for specifics.

## Medical Coverage Eligibility

**Eligible Employees** - are full-time employees working 34 or more hours per week. \*

**Eligible Dependents** – are a spouse under a legally existing marriage and children who are less than 26 years old, including adopted children and stepchildren.

*\*Employees must be actively-at-work on the effective date of coverage; otherwise, coverage will not go into effect until the employee returns to active work.*

Participation in your assigned Blue Cross Blue Shield of Tennessee PPO Network "S" maximizes benefits and reduces your cost. It's **your** responsibility to make sure ALL providers you use (hospitals, doctors, pharmacies, labs, etc.) are in your Blue Cross Blue Shield of Tennessee "S" Network.

## When do you need to enroll?

- **As a new hire** – Within 10 days of notification of eligibility to enroll.
- **During annual enrollment** – You can elect (or make changes) only one time each year during annual enrollment unless you experience a qualifying event/change in status. Request the medical Summary Plan Description (SPD) for specifics of these events.

### If you miss the deadline:

- **As a new hire** – If benefits are not elected when you are first eligible you will not have Tony's Foodland benefits. You will then have to wait until the next annual enrollment to elect benefits unless you have a qualifying event/change in status.
- **During annual enrollment** – Your current benefit elections will continue, as is, if no changes are made during this annual enrollment period.

## How to make changes during the year?

During the year you may make changes only if you experience a qualifying event/change in status (e.g. marriage, divorce, birth or adoption, gain or loss of other coverage).

Remember to make changes within 31 days of the qualifying event/change in status or you will have to wait until the next annual enrollment period.

For complete information, please see your medical Evidence of Coverage (EOC)/Summary Plan Description (SPD) for specifics.

Contact Tony Hunter at 615-876-2203 for questions and comments.

## Your New Hire Enrollment Checklist

Complete this checklist, read the guide, use the online resources provided to help you make decisions based on your needs and circumstances during your New Hire enrollment period:

- Understand how your health, HSA, Pre-Tax and voluntary plans work such as the PPO Network, enrollment limits, deductibles, claims, coinsurance, exclusions, etc.

Consider the cost of the benefits for you and your dependents.

- Complete the appropriate enrollment and/or waiver forms.
- Check your providers in the Blue Cross BlueShield of Tennessee "S" Network in which Tony's Foodland participates.
- Go to [www.bcbst.com](http://www.bcbst.com) Manage My Plan, Find Doctors and Hospitals or register for Blue Access.
- Call Member Service toll-free at 800-565-9140 Monday through Friday 8:00 a.m. to 6:00 p.m. Eastern Time.

*If there is a discrepancy between the information shown in the Annual Enrollment Summary and information shown in the master contracts, the provisions of the master contracts will govern. Tony's Foodland reserves the right to amend, terminate, suspend, withdraw or modify the plans or change contributions at any time for any reason. There is neither vesting in benefits nor a vested right to the benefits.*



**MEDICAL PLAN SUMMARY- TONY'S FOODLAND**

**BlueCross BlueShield of Tennessee Network "S" – Consumer Driven Health Plan – HSA Qualified**

<b>Your PPO Benefits Include the Following:</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Annual Maximum	Unlimited	
Medical and Prescription Drug Deductible Per Calendar Year	Individual \$ 7,400 Family \$14,800	Individual \$14,800 Family \$29,600
Out-Of-Pocket Per Calendar Year (including Deductible)	Individual \$ 7,400 Family \$14,800	Individual \$22,200 Family \$44,400
Benefits/Coinsurance for Covered Wellness Services	100% Deductible Waived	50% After Deductible
Benefits/Coinsurance for most other covered services including inpatient and outpatient hospital services, physician office visits, emergency room services, prescription (except preventive) drugs such as generics, preferred brand and non-preferred brands.	100% after deductible	50% after deductible

**If You Use Network Providers**

- Network "S" providers offer discounts that save money for you and the Tony's Foodland medical plan.
- You cannot be billed for any amount (other than your deductible, coinsurance or co-pay) over the allowable charges for covered services.
- Network providers will file your claims for you.
- You will be responsible for paying any applicable deductibles, coinsurance and/or non-covered charges as determined by your benefit plan.
- Wellness Benefits are covered at 100% (no deductible) provided you use a provider in the Blue Cross "S" Network.
- To find a Network "S" provider, go to [www.bcbst.com](http://www.bcbst.com), select "Manage My Plan," and select "Doctors and Hospitals."

**If You Use Non-Network Providers**

- The out-of-network deductible and out-of-pocket limits are higher.
- You will have to pay for charges that exceed the allowable charge.
- You will have to pay the provider the full amount during the visit and file a claim for reimbursement.
- Wellness benefits are covered at 50% after your deductible has been met.

**Prescription Drug Benefit**

- Using generic prescriptions instead of brand name prescriptions saves money for you and the Tony's Foodland medical plan.

You will receive an SBC – Summary of Benefits and Coverage – with more details.

**Employee Action to be Taken: If you want to enroll/terminate participation in the Comprehensive Medical Plan please complete the Blue Cross-Blue Shield election/termination form and return to Tony Hunter within 10 days of being notified of new hire eligibility.**

**Note that if you do not make any New Hire elections you may have to wait until Annual Enrollment to apply unless you experience a qualifying event/change in status.**

NOTE: Tony's Foodland **generously** contributes 65% toward employee only premiums. Premium for any eligible dependent is 100% paid by the employee.

Please see Tony for specifics.



## About the Health Savings Account

Tony's Foodland medical plan is an IRS approved medical plan that qualifies for a Health Savings Account (HSA). Health Savings Accounts, or HSAs, are a popular type of medical reimbursement plan. HSA's are individual bank accounts owned by employees that allow for tax-free payment or reimbursement of eligible medical expenses.

**Who can establish an HSA?** The IRS has strict guidelines to determine who is eligible to own and contribute to an HSA. Under the law, you are eligible if:

- You are covered by a single or family high-deductible health plan.
- You are not covered by any other health plan, unless it is also a qualifying high-deductible health plan.
- You are not enrolled in Medicare.
- You are not claimed as a dependent on another person's tax return, excluding your spouse.

**Who owns the HSA?** You do.

**Who can put money in my HSA?** Anyone can contribute to your HSA. However, only the account holder receives tax deductions on monies contributed.

**Do I have to claim HSA contributions from others on my income taxes?** You don't have to claim contributions you receive from others as gross income on your annual federal tax return.

**How much money can I contribute to my HSA?** In 2025, the maximum annual contribution as set by the IRS for an individual account is \$4,300 and the maximum contribution for family coverage is \$8,550. People age 55 and over can make an additional "catch-up" contribution of \$1,000.

**What happens to the money in my HSA if I leave my job or retire?** You take that money with you wherever you go. The HSA is in your name. It's your account. If you're on Medicare or go to another employer that doesn't have a qualified high deductible health plan similar to the Blue Shield Health Savings Plan, you can still use your HSA money to pay for co-pays and qualified medical expenses, but you won't be able to continue to make contributions to your HSA.

**Does the money I have in my HSA roll over from year to year, or do I lose the money at the end of the year?** The money rolls over from year to year. You don't lose the money left in your HSA or the interest it's earned. It's your money.

**Can I take the money out of my HSA any time I want?** Yes. You can take money out anytime tax-free and without penalty as long as it's to pay for qualified medical expenses. If you take money out for other purposes, however, you'll have to pay income taxes on the withdrawal plus a 20 percent penalty.

**Can I use the money in my HSA for non-medical expenses?** Yes. If you do though, and are under 65, you'll be taxed on the amount you use and assessed a 20 percent penalty. Once you're 65, you'll be taxed for monies used for non-medical expenses, but won't pay a penalty.

**Can I use my HSA for eyeglasses, contacts or LASIK surgery?** Yes. These expenses will not apply to your insurance deductible though.

**Can I use my HSA to pay for dental expenses and orthodontics?** Yes. These expenses will not apply to your insurance deductible, though.

**How to enroll?** Complete the HSABank enrollment form and give to Tony.

**Employee Action to be Taken:** *If you want to enroll/terminate participation in the Health Savings Account (HSA) plan please complete the HSA election/termination form and return to Tony Hunter or call the HSABank Client Assistance Center at (800) 357-6246.*

Note that if you do not make any New Hire elections you may have to wait until Annual Enrollment to apply unless you experience a qualifying event/change in status.



## TIPS FOR SAVING MONEY ON YOUR HEALTHCARE

- ✓ **Commit to eating well, exercise regularly and steer clear of unhealthy habits such as smoking and excessive alcohol consumption.**
- ✓ **Get preventive screenings, well visits and physicals which give you and your doctor an opportunity to discuss goals and necessary medical advice. Preventive screenings may catch issues before they become serious.**
- ✓ **Use your Blue Cross Blue Shield of Tennessee **Network "S"**.**
- ✓ **Make sure you are following your doctor's guidelines for chronic conditions such as diabetes, high blood pressure, heart disease, etc.**
- ✓ **Use generic drugs whenever possible. Ask your doctor or pharmacist to prescribe generics whenever possible.**
- ✓ **Avoid the emergency room at hospitals for non-emergencies. Utilize telemedicine, your doctor or convenient care clinics in your area for non-emergency services.**
- ✓ **Consult with your doctor or insurance company about lower cost options and alternatives for medical care, services, equipment and prescriptions.**
- ✓ **Utilize Blue Cross Blue Shield's online services for members at <http://www.bcbst.com>.  
Go to manage plans and...**
  - **Cost Estimator** - Find out how you can save money on more than 1,400 common medical procedures with our HealthCare Cost Estimator. Results are based on your specific health benefits, copay, deductible and out-of-pocket costs.
  - **Cost Saving tips** - Saving money on health care starts with making simple, smart choices. Here are some tips for saving on many of your medical costs such as doctor appointments, surgical procedures, prescriptions and more.
  - **Health and Wellness** – Well Tuned Blog, information, resources, etc.
  - **BlueHealth™ Solutions** – Getting fit, living healthy and health conditions.
  - **Member Discounts** – Save on fitness, eat well for less, free ID Theft protection & personal care discounts.
  - **Food and Nutrition** – Food facts, recipes and food plan.
  - **Blue Cross - MyBlueTN** phone app available on Google Play for Android and App for Apple Users. Review claims, EOB's, benefits,lookup providers, and more. Must have subscriber card to setup.

**Telemedicine:** For more information visit Teladoc at <https://www.bcbst.com/get-care/teladoc>

- Telemedicine is included in your Blue Cross medical plan with a program called Teladoc.
- It may not always be convenient to go to the doctor. BCBST offers you the choice to call or video chat with a doctor for non-emergency situations.
- Teladoc gives you 24/7/365 access to a doctor through the convenience of phone or video consults. It's an affordable option for quality medical care.
  - Teladoc telemedicine is great for general health issues such as allergies, cold and flu, sinus Infections, respiratory issues, skin conditions (rashes or insect bites), sore throats and other issues.
- **Great** for college students away from home
- Teladoc telemedicine phone app available on Google Play for Android and App for Apple Users.
- Set your telemedicine app up now so it will be ready when you need it. Must have Blue Cross subscriber card to activate.

## CAFETERIA PLAN – PRE-TAXING BENEFITS - TONY’S FOODLAND

Tony’s Foodland’s Cafeteria Plan is voluntary, and is designed for use with Section 125 of the Internal Revenue Service Code.

A Section 125 “Cafeteria” Plan allows employees to pay for certain benefits with pre-tax dollars. As a result, the employee’s taxable income decreases and their take home pay increases. The following is an example of how the Tony’s Foodland Cafeteria Plan works and how it affects a typical paycheck.

Example: Employee making \$16,900 per year and contributing **\$75.00** biweekly to an employer-sponsored medical plan.

	<u>WITHOUT</u> Tony’s Foodland Cafeteria Plan (Pre-Tax Plan)	<u>WITH</u> Tony’s Foodland Cafeteria Plan (Pre-Tax Plan)
Biweekly Pay	\$650.00	\$650.00
Less contribution		- 75.00
Taxable Income	\$650.00	\$575.00
*Less 15% Federal tax (estimated)	- 97.50	- 86.25
*Less 7.65% FICA tax (estimated)	- 49.73	- 43.99
Net	\$502.77	\$444.76
Less contribution	- 75.00	
Biweekly Take Home Pay	\$427.77	\$ 444.76
<b>Increase in Biweekly Take Home Pay</b>		<b>+ \$16.99</b>

Once you enroll in the Tony’s Foodland Cafeteria Plan, the IRS requires that you maintain the plan for the entire policy year unless you have a change in status/qualifying event. Here are some examples of qualifying event/change of status:

- Change in marital status (e.g. marriage, divorce)
- Change in number of dependents
- Change in employment status
- Change in eligibility requirements
- Adoption proceedings
- Change in cost or coverage
- Other laws or court orders

*Employee Action to be Taken: If you want to enroll/terminate participation in the Pre-tax Plan, complete the Pre-Tax election/termination form and return to Tony Hunter within 10 days of being notified of new hire eligibility.*

Note that if you do not make any New Hire elections you may have to wait until Annual Enrollment to apply unless you experience a qualifying event/change in status.

\*Taxes shown above are for illustrative purposes only and may fluctuate based on taxes in place at the actual time of contribution.

Due to recent tax changes you should consult your tax professional or adviser for your specific needs and tax benefits.



## American Family Life Assurance Company (AFLAC)

Tony's Foodland offers voluntary plans offered by AFLAC:

- **Accident:** Helps pay for emergency room or doctor visits due to any type of injury, x-rays, follow up visits, physical therapy, hospital stays, ambulance, intensive care and more. Includes Accidental Life Insurance of \$25,000.
- **Cancer:** Initial diagnosis benefit, benefits for hospitalization, surgery, chemotherapy, radiation and more. Includes a cancer screening, wellness benefits and mammography benefit with two different levels from which to choose.
- **Short Term Disability** (paycheck insurance): Insures you up to 60% if you are unable to work due to a sickness or off the job injury. Benefits for childbirth included after 10 months. Rates based on age and income.
- **Term Life Insurance** – Life insurance available with spouse & child riders.

Specific cost of AFLAC plans will be provided by Your AFLAC Representative Kandi Heckler

You may contact Kandi by phone or email: 615-243-8800 or [Kandi\\_Heckler@us.aflac.com](mailto:Kandi_Heckler@us.aflac.com).

Log-In to Register and Manage Your Account: <https://phs.aflac.com/aflac.phs.app/account/login>.

AFLAC SmartClaim® Mobile App available at Apple App Store and Google Play.

Please contact Kandi directly with questions and to assist with claims.

***Note that if you do not make any New Hire elections you may have to wait until Annual Enrollment to apply unless you experience a qualifying event/change in status.***

2024-2025 NEW HIRE ENROLLMENT - TONY'S FOODLAND

Confirmation of Receipt of New Hire Enrollment Guide

Employee Name (Print) \_\_\_\_\_

I am aware that TONY'S FOODLAND's New Hire enrollment period is \_\_\_\_\_

I have reviewed my options and my election is confirmed below (check one of options below):

\_\_\_\_\_ I want to enroll in the medical plan and have completed the applicable enrollment for me and/or my eligible dependents.

\_\_\_\_\_ I have elected **not** to participate in Tony's Foodland's medical plan

\_\_\_\_\_ I have completed my Cafeteria Section 125 (Pre-Tax) Plan enrollment form and the effective date is \_\_\_\_\_ (insert date)

\_\_\_\_\_ I have elected **not** to participate in Tony's Foodland's Cafeteria Section 125 (Pre-Tax) Plan.

Date Signed \_\_\_\_/\_\_\_\_/\_\_\_\_ Signature \_\_\_\_\_

*If there is a discrepancy between the information shown in the Annual Enrollment summary and information shown in the master contracts, the provisions of the master contracts will govern. Tony's Foodland reserves the right to amend, terminate, suspend, withdraw or modify the plans or change contributions at any time for any reason. There is neither vesting in benefits nor a vested right to the benefits.*

**Employee Action to be Taken - You must complete this form and return to Tony Hunter within 10 days of being notified of new hire eligibility.**

2024-2025 CAFETERIA PLAN – PRE-TAX ELECTION/WAIVER OF COVERAGE FORM - TONY'S FOODLAND

Name (Print) \_\_\_\_\_

\_\_\_\_ I elect to participate in the Tony's Foodland Cafeteria Plan. By doing so, I understand that IRS regulations require that I remain in this plan for which I have elected to pre-tax contributions for 12 months unless I experience a qualifying event/change in status as defined by examples at the bottom of this page.

\_\_\_\_ I elect **not** to participate in the Tony's Foodland Cafeteria Plan.

**Note: At annual enrollment if you are enrolled and do not make any changes, your current election will remain in force for the new plan year.**

I also understand that at any time, the Tony's Foodland Cafeteria Plan may be amended or terminated for any reason, including by operation of law.

Date Signed \_\_\_\_/\_\_\_\_/\_\_\_\_ Signature \_\_\_\_\_

Qualifying Events:

- Marriage
- Birth
- Adoption or placement for adoption
- Divorce, legal separation or annulment of an employee's marriage
- Death of spouse or dependent
- Change in employee's, spouse's or dependent's employment status that affects eligibility under their plan
- Spouse's employer makes significant changes in coverage or premium costs (30% or greater change)
- Spouse is provided group insurance through employer for the first time
- Reinstatement of coverage terminated due to non-payment of premium
- Dependent no longer meets eligibility criteria or becomes ineligible for other coverage
- Court order results in the employee gaining or losing custody of a dependent
- Dependent becomes eligible
- Coordination of spouse's annual election period
- Court decree establishes an employee's financial responsibility for a child's medical, dental or other health care
- Change in Public Aid recipient status or Medicare status
- Change in employee's county of residence or work location (cannot add or drop dependent coverage in this case)
- Change in managed care plan due to primary care provider leaving the network

**Employee Action to be Taken - You must complete this form and return to Tony Hunter within 10 days of being notified of new hire eligibility.**

2024-2025 PAYROLL DEDUCTION AUTHORIZATION – TONY’S FOODLAND

I, \_\_\_\_\_, hereby authorize Tony’s Foodland to deduct from  
(Employee’s Printed Name)

my wages for Blue Cross – Blue Shield medical insurance in the sum of \$ \_\_\_\_\_.  
(Deduction per pay period)

\_\_\_\_\_  
(Date Signed)

\_\_\_\_\_  
(Employee’s Signature)

\_\_\_\_\_  
(Employee’s Social Security Number)

**Employee Action to be Taken - You must complete this form and return to Tony Hunter within 10 days of being notified of new hire eligibility.**

## Tony's Foodland Notice of Electronic Notification of Information

From time to time Tony's Foodland will distribute notices, benefits information, summary plan documents, notices required by government entities to you, our valued associates. In order to conserve resources and to make available to you at your convenience, Tony's Foodland has created an online, internet web site called **Benefits-Assist™** that will contain notices, benefits information, summary plan documents, notices required by government entities, etc. provided to our employees. The web site is secure but free of cost to you to access and use. At any time if you elect a paper copy of any notices there is no cost to you.

Benefits-Assist™ Address: [TonysFoodlandBenefits.com](http://TonysFoodlandBenefits.com)  
Benefits-Assist™ Password: **TfB5529**

You will need access to the internet, a normal web browser (Internet Explorer, Mozilla Firefox, Google Chrome, etc.) as well as web site address, username and password shown above. The current list of documents includes, **but is not limited to:**

- Group Blue Cross Medical Summary of Benefits and Coverage (SBC)
- Summary Plan Description (SPD)
- Creditable Coverage Notice Disclosure
- WHCRA - NOTICE OF COMPLIANCE WITH THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998
- Group Blue Cross Medical Evidence of Coverage (EOC)
- Group Pre-Tax (Cafeteria Plan)
- AFLAC – Cancer, Life Insurance, Accident and Short-Term Disability - Individual Policy Contact Information

This list will be updated as mandated by various notices, benefits information, summary plan documents, notices required by government entities, etc. You should check back weekly for updates. If you would prefer a paper copy of the summaries, please make a request to Tony Hunter at 615-876-2203.

You may elect to withdraw from electronic notification at any time and receive paper copies instead. In order to receive paper notification in lieu of electronic notification, please make your request in writing, sign and date and give to Tony Hunter. If you elect to receive paper notifications, please allow for 60-90 days for the conversion from electronic to paper notification.

In order to access information electronically, I must have:

- An electronic device with internet connection (i.e. home computer, laptop, tablet, smart-phone, etc.).
- .pdf viewer such as FREE Adobe Acrobat Reader (installed on most electronic devices) but available at: <https://get.adobe.com/reader/>

If you have any questions, suggestions or need additional information or clarification, please contact Tony Hunter at 615-876-2203.

Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Employee Action to be Taken - If you elect electronic notification please complete this form and return it to Tony Hunter within 10 days of being notified of new hire eligibility.**

**If you notice any errors in this New Hire Guide, or in the Benefits-Assist™ web site, please call Mark Fessenden at 615-218-0349 to report needed corrections.**



1 Cameron Hill Circle  
Chattanooga, TN 37402-0001  
bcbst.com  
- CONFIDENTIAL -

# EMPLOYEE ENROLLMENT / WAIVER

PLEASE USE BLUE OR BLACK INK ONLY  
IF YOU ARE DECLINING COVERAGE, PLEASE GO TO BACK OF FORM.

Plan Use Only  
Rec: \_\_\_\_\_

EEW-15

**Section 1 - Group / Employer Information - This form cannot be processed without this information**

GROUP NO. 112703 SUBGROUP NO. \_\_\_\_\_ DEPARTMENT NO. \_\_\_\_\_ GROUP NAME Tony's Cee Bee, Inc.

COVERAGE EFFECTIVE DATE: Medical   /  /   Dental   /  /   Vision   /  /   FSA   /  /  

NEW ENROLLMENT (CHECK IF APPLICABLE):  
 New Hire  Open Enrollment  Rehire

Part-time change to Full-time  
Full-time Date of Hire:   /  /   Hrs Wkd/Wk     
Part-time / Rehire Date:   /  /  

QUALIFYING EVENT:  
 Loss of Other Medical Cvg  Loss of Other Dental Cvg  
 Loss of Other Vision Cvg  Marriage  New Dependent Child  
 Court Order  Other (FSA Only)  Continuation Coverage Period Expired  
EVENT DATE:   /  /  

COBRA OR  STATE CONTINUATION:  
 Termination of Employment (Voluntary or Involuntary)  Employee Eligible for Medicare  
 Reduction in Hours  Dependent Child No Longer Eligible  
 Divorce/Legal Separation  Death of Employee  
EVENT DATE:   /  /  

**Section 2 - Employee/Member Information - Employee Must Complete In Full**

ELECT: Medical Option:  1  2  3  4 Other \_\_\_\_\_  Ind  Fam  EE/Spouse  EE/Child(ren)

ELECT: Dental Option:  1  2  3  4 Other \_\_\_\_\_  Ind  Fam  EE/Spouse  EE/Child(ren)

ELECT: Vision Option:  1  2  3  4 Other \_\_\_\_\_  Ind  Fam  EE/Spouse  EE/Child(ren)

ELECT: FSA:  Health Care: \$   /  /   Annual Pledge Amount\*  
 Dependent Care: \$   /  /   Annual Pledge Amount\*  
If your Group does not offer a debit card with FSA, should BCBST automatically pay Health Care FSA funds when medical claims are processed?  YES  NO

**OTHER INSURANCE**  
If you or listed dependents will be covered by other medical/Medicare or dental insurance when this plan goes into effect, indicate which coverage.  
 Medical/Medicare  Dental  
HICN   /  /  

EMPLOYEE LAST NAME \_\_\_\_\_ EMPLOYEE FIRST NAME \_\_\_\_\_ MI \_\_\_\_\_ JR., SR., ETC. \_\_\_\_\_ SSN/TIN\*\* \_\_\_\_\_ DATE OF BIRTH   /  /   Male  Female

ADDRESS \_\_\_\_\_  SPANISH IS MY PRIMARY HOUSEHOLD LANGUAGE  
CITY (Please do not abbreviate) \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ EMAIL ADDRESS\*\*\* \_\_\_\_\_

PAID CLASSIFICATION  Hourly  Salary  Retiree  Surviving Spouse | JOB CLASSIFICATION  Management  Non-Management  Exec/Officer/Owner JOB TITLE \_\_\_\_\_ PAYROLL NO. \_\_\_\_\_

**Section 3 - Acknowledgement - Signature and Date MUST BE COMPLETED**

Employee should notify BlueCross BlueShield of Tennessee if any dependent's address is different from the employee's address. It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of coverage. I understand, and agree, that I am applying for coverage and: 1) that any contract which may be issued to me will be subject to all the terms and conditions of the Group Agreement; 2) that my signature on this form will authorize any doctor, hospital, or other provider of treatment to furnish BlueCross BlueShield of Tennessee any and all medical records pertaining to any person covered by the contract; 3) that I am responsible for any fee for these records; and 4) that Health and Dependent Care Flexible Spending Accounts (FSAs) are on a pre-tax basis and they cannot be changed prior to the end of the plan year unless a change in status event occurs as defined in the Summary Plan Description and I will forfeit any amount remaining in the account after all eligible expenses are submitted for reimbursement should I over estimate my annual needs.

Employee's Signature: X Date:   /  /   Phone:   -  -  

\*Annual maximum applies. See your Benefits Administrator if you have questions. \*\*To comply with Federal regulations we must have SSN/TIN. \*\*\*By providing your email address, you are agreeing to receive all communications (presently available or that become available during the term of your policy) related to this policy, the benefits considered under this policy, your relationship with BCBST, etc., in electronic form from BCBST or its subsidiaries.

GROUP NO. \_\_\_\_\_

EMPLOYEE LAST NAME \_\_\_\_\_

EMPLOYEE FIRST NAME \_\_\_\_\_

EEW-15

Section 4 - Dependent Information - Please provide all information for each person to be covered. Consult employer guidelines for dependent eligibility.

SPOUSE LAST NAME \_\_\_\_\_ SPOUSE FIRST NAME \_\_\_\_\_ MI \_\_\_\_\_ JR., SR., ETC. \_\_\_\_\_ DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_ Male  Female  SSN/TIN\*\* \_\_\_\_\_

(1) DEPENDENT LAST NAME \_\_\_\_\_ DEPENDENT FIRST NAME \_\_\_\_\_ MI \_\_\_\_\_ JR., SR., ETC. \_\_\_\_\_ DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_ Male  Female  SSN/TIN\*\* \_\_\_\_\_

Natural Child/Stepchild  Adopted/Legal Guardian  Other (specify) \_\_\_\_\_  Physically Handicapped  Full-time Student Over 19

(2) DEPENDENT LAST NAME \_\_\_\_\_ DEPENDENT FIRST NAME \_\_\_\_\_ MI \_\_\_\_\_ JR., SR., ETC. \_\_\_\_\_ DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_ Male  Female  SSN/TIN\*\* \_\_\_\_\_

Natural Child/Stepchild  Adopted/Legal Guardian  Other (specify) \_\_\_\_\_  Physically Handicapped  Full-time Student Over 19

(3) DEPENDENT LAST NAME \_\_\_\_\_ DEPENDENT FIRST NAME \_\_\_\_\_ MI \_\_\_\_\_ JR., SR., ETC. \_\_\_\_\_ DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_ Male  Female  SSN/TIN\*\* \_\_\_\_\_

Natural Child/Stepchild  Adopted/Legal Guardian  Other (specify) \_\_\_\_\_  Physically Handicapped  Full-time Student Over 19

Section 5 - Ancillary Insurance Information (NOTE: Products are offered by US Able Life or other carriers which are independent and solely responsible. These are NOT BlueCross BlueShield products.)

ELECT (Mark all that apply):  Basic Life/ADD  Dependent Life  STD  LTD  Supplemental Life/ADD Life Class \_\_\_\_\_ Annual Salary \$ \_\_\_\_\_ .00

BASIC LIFE INSURANCE AMT	\$	OR	TIMES SALARY	BENEFICIARY	RELATIONSHIP	PERCENTAGE	BENEFICIARY	RELATIONSHIP	PERCENTAGE
N/A	_____ .00		_____	1	N/A		3		
SUPPLEMENTAL LIFE/ADD AMT	\$		_____	2			4		

Section 6 - Waiver of Coverage - Complete this section to waive coverage, however, your Employer may require an additional, separate waiver form.

DECLINE COVERAGE - I understand that I have been offered, and have declined, coverage sponsored by my employer.  
Medical  Dental  Vision  Basic Life/ADD  Dependent Life  STD  LTD  Supplemental Life/ADD

Reason for declining (Mark all that apply):  
 Other group medical coverage  Other group dental coverage  
 Other group vision coverage  I have TennCare  
 Other

GROUP NO. 112703 GROUP NAME Tony's Cee Bee, Inc.

EMPLOYEE LAST NAME \_\_\_\_\_ EMPLOYEE FIRST NAME \_\_\_\_\_ EMPLOYEE DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_ WAIVER SIGNATURE (Note: Signature also required in Section 3 when electing any coverage) X DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

Special Enrollment Period for Medical, Dental and Vision: An Employee or eligible dependent who did not apply for coverage within thirty-one (31) days of first becoming eligible for coverage under this Plan may enroll if: 1) he or she had other health care coverage at the time coverage under this plan was previously offered; and 2) he or she stated, in writing, at the time coverage under this Plan was previously offered, that such other coverage was the reason for declining coverage under this Plan; and 3) such other coverage is exhausted (if the other coverage was continuation coverage under COBRA) or the other coverage was terminated because he or she ceased to be eligible due to involuntary termination or employer contributions for such coverage ended; and 4) he or she applies for coverage under this Plan and the administrator receives the change form within thirty-one (31) days after the loss of other coverage. The Employee also may enroll at the next Open Enrollment Period.

# Health Savings Account (HSA) Application and Eligibility Form

HSA offered through employer – Upon completion, submit this form to your employer.

**Employer Federal Tax ID or Employer Code:** \_\_\_\_\_

HSA not offered through employer – Upon completion, mail this form to HSA Bank, P.O. Box 939, Sheboygan, WI 53082; fax to 920-803-4184; or email to [hsaforms@hsabank.com](mailto:hsaforms@hsabank.com). (Alternatively, you may apply online at [hsabank.com](http://hsabank.com).)

If you need assistance, our U.S.-based Client Assistance Center has representatives available 24 hours a day, 7 days a week, at 800-357-6246.

\*Required

Part 1: General Information for Primary Accountholder								
*First Name:		MI:	*Last Name:		*Date of Birth (mm/dd/yyyy) (Must be 18):		*Social Security Number:	
*Physical Street Address:					*City:		*State:	*ZIP:
*Preferred Mailing Address: <input type="checkbox"/> Physical Street Address <input type="checkbox"/> P.O. Box				Email:				
P.O. Box:				City:		State:	ZIP:	
*Home Phone:				Business Phone:				
*Citizenship Status: <input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Resident Alien <input type="checkbox"/> Non-Resident Alien				Country of Citizenship if Not a U.S. Citizen:				
*Health Plan Insurance: <input type="checkbox"/> Single <input type="checkbox"/> Family/Single + Dependent(s)		*Effective Date of Your Health Insurance:			*Deductible Amount: \$			
Part 2: Employment Information (Note: The Employer Federal Tax ID or Employer Code above is <u>required</u> for an employer-offered HSA.)								
*Employment Status: <input type="checkbox"/> Employed <input type="checkbox"/> Self Employed <input type="checkbox"/> Not Employed/Retired				Employer Name: (Required if employed/self employed)				
Part 3: Authorized Signer (Such as a Spouse or Another Third Party) – Optional								
By completing all of the fields below, you are authorizing the person designated as “authorized signer” to access and initiate transactions on your account as your agent. HSA Bank will rely upon this designation until HSA Bank receives your written revocation of this authorization and has had a reasonable time to act upon it. You hold harmless and indemnify HSA Bank against any claims against or losses arising out of HSA Bank’s reliance on this authorization, and release HSA Bank from any liability arising from such reliance, unless otherwise prohibited by law. You remain solely responsible for any tax consequences that result from any actions taken by the authorized signer regarding your account. <b>Important:</b> If you wish to designate an authorized signer to your account, all fields in this section are <b>required</b> .								
First Name:		MI:	Last Name:		Date of Birth (mm/dd/yyyy):		Social Security Number:	
<input type="checkbox"/> Address same as accountholder			Street Address:					
City:			State:	ZIP:	Phone Number:			
If you would like to designate a beneficiary for your account, please complete our <i>HSA Designation of Beneficiary Form</i> , which is available on our website at: <a href="http://hsabank.com/BeneficiaryForm">hsabank.com/BeneficiaryForm</a> . Alternatively, you may designate a beneficiary for your account on HSA Bank’s Member Website after your account is opened. If you fail to designate a beneficiary, then your estate will be your beneficiary upon your death.								
Part 4: Account Selections								
*Please select the account options and enter an amount where appropriate.								
<input type="checkbox"/> Primary accountholder debit card (no charge) (Note: We do not charge for the first two debit cards on your account. Additional cards are \$6.00 each.)								
<input type="checkbox"/> Authorized signer debit card (if applicable)								
<input type="checkbox"/> Checks (\$7.95 – check must be included to process order)				\$ _____				
<input type="checkbox"/> Initial contribution				\$ _____ Contribution Year: _____				
*Transfer: <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please attach the HSA transfer/rollover form or IRA form.)								
Part 5: Account Authorization								
By signing below, I certify that:								
<ul style="list-style-type: none"> <li>I am or will be covered by an HSA-qualified high deductible health plan (HDHP), I am not enrolled in Medicare or covered under other health insurance that is not compatible with an HSA, and I may not be claimed as a dependent on another person’s tax return (excluding spouses per the Internal Revenue Service [IRS]).</li> <li>HSA Bank is hereby appointed to serve as custodian of my Health Savings Account.</li> <li>To help the government fight the funding of terrorism and money laundering activities, federal law requires that all financial institutions obtain, verify, and record information that identifies each person who opens an account. What this means to you: when you open an account, we will need you and your authorized signer to provide name, street address, date of birth, and other information that will enable us to identify you and your authorized signer. We may also ask to see your driver’s license or other identifying documents.</li> </ul>								
After your application is processed, you will receive a Welcome Kit by mail in 7-10 business days. The Welcome Kit contains your account number and account disclosures. It also outlines our services and provides details on how to manage your account. Your debit card and any debit card requested for an authorized signer will each arrive in a separate envelope about 10-14 business days after your application is processed. If you don’t receive your Welcome Kit or debit card(s), please contact us at 800-357-6246.								
*Accountholder Signature:						*Date:		
For Tracking Purposes (to be completed by employer or insurance/financial representative)						Internal Use Only:		
Health Plan Code	Broker Dealer	AIN#	SVC	Software	MGA	Marketing		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		