Graduate Medical Education

Resident/Fellow – 2023 Enrollment Form

NAME: _____

Address: _____ **City**: _____

St: _____ **Zip:** _____ **Email:** _____

Soc Sec#: _____ **Birthdate:** _____ (Month / Date / Year) **Email:** _____

Hire date: _____ **Phone:** _____ **Sex:** □M or □F

	Last, First	Social Security #:	Sex:	Birthdate:
Spouse:			□M or □F	
Child:			□M or □F	
Child:			□M or □F	
Child:			□M or □F	
Child:			□M or □F	

(Identify the OPTION you prefer, then Check only one BOX for coverage)

OPTION 1

Monthly Employee Cost	
☐ Employee Only	$35.00
☐ Family	$75.00

BLUE CROSS BLUE SHIELD OF TN - HEALTH

Deductible: Individual/Family $500/$1,500
Maximum Out of Pocket: Individual/Family $1,500/$4,500
Prescription Drug: $10/$45/$90

BLUE CROSS BLUE SHIELD OF TN - DENTAL

In- Network Deductible: $0
Annual Max: $1,000

Monthly Employee Cost: [√] **$0.00**

BLUE CROSS BLUE SHIELD OF TN - VISION

Exam: $10 Copay
Materials: $0 Copay

Monthly Employee Cost: [√] **$0.00**

OPTION 2 - DECLINE

I am DECLINING Health, Dental, & Vision because_____ ☐

Life

Amount: $50,000
AD&D: $50,000

Beneficiaries:

_____ Relationship:_____ %_____
_____ Relationship:_____ %_____
_____ Relationship:_____ %_____

Monthly Employee Cost:
[√] **$0.00**
[√] **$0.00**

Long Term Disability

Benefit Amount: $1,000
Waiting Period: 90 Days
Benefit Period: to age 65

Monthly Employee Cost:
[√] **$0.00**
[√] **$0.00**

Employee Signature: _____

Date: _____

**For more details, please ask GME Office for a full Summary of Benefits or SBC.*