



STATE OF TENNESSEE GROUP INSURANCE PROGRAM

ANNUAL ENROLLMENT APPLICATION FOR RETIREE PARTICIPANT

State of Tennessee • Department of Finance and Administration • Benefits Administration
312 Rosa L. Parks Avenue, 19th Floor • Nashville, Tennessee 37243 • 800.253.9981 • fax 615.741.8196



PART 1: RETIREE INFORMATION

LAST NAME		FIRST NAME		MI	SOCIAL SECURITY NUMBER OR EDISON ID	
DATE OF BIRTH	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS	ARE YOU THE SURVIVING SPOUSE OF A DECEASED RETIREE? <input type="checkbox"/> Yes <input type="checkbox"/> No		AGENCY RETIRED FROM	
HOME ADDRESS			CITY	ST	ZIP CODE	COUNTY

PART 2: HEALTH COVERAGE SELECTION

<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Cancel	<input type="checkbox"/> Retiree <input type="checkbox"/> Spouse <input type="checkbox"/> Child	SELECT A BENEFIT OPTION <input type="checkbox"/> Partnership Promise PPO <input type="checkbox"/> No Partnership Promise PPO <input type="checkbox"/> Standard PPO <input type="checkbox"/> HealthSavings CDHP <input type="checkbox"/> Limited PPO (local education and local government only)	SELECT A CARRIER <input type="checkbox"/> BlueCross BlueShield Network S <input type="checkbox"/> Cigna LocalPlus <input type="checkbox"/> Cigna Open Access (surcharge applies)	SELECT A PREMIUM LEVEL <input type="checkbox"/> retiree only <input type="checkbox"/> retiree + child(ren) <input type="checkbox"/> retiree + spouse <input type="checkbox"/> retiree + spouse + child(ren)	<input type="checkbox"/> spouse ONLY <input type="checkbox"/> child(ren) ONLY <input type="checkbox"/> spouse + child(ren) ONLY
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PART 3: DENTAL COVERAGE SELECTION **PART 4: VISION COVERAGE SELECTION**

<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Cancel	<input type="checkbox"/> Retiree <input type="checkbox"/> Spouse <input type="checkbox"/> Child	SELECT PLAN <input type="checkbox"/> MetLife DPPO <input type="checkbox"/> Cigna Prepaid DHMO	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Cancel	<input type="checkbox"/> Retiree <input type="checkbox"/> Spouse <input type="checkbox"/> Child	SELECT PLAN <input type="checkbox"/> Basic <input type="checkbox"/> Expanded
SELECT A PREMIUM LEVEL <input type="checkbox"/> retiree only <input type="checkbox"/> retiree + child(ren)		<input type="checkbox"/> retiree + spouse <input type="checkbox"/> retiree + spouse + child(ren)	SELECT A PREMIUM LEVEL <input type="checkbox"/> retiree only <input type="checkbox"/> retiree + child(ren) <input type="checkbox"/> retiree + spouse		<input type="checkbox"/> retiree + spouse + child(ren) <input type="checkbox"/> spouse ONLY <input type="checkbox"/> child(ren) ONLY <input type="checkbox"/> spouse + child(ren) ONLY

PART 5: DEPENDENT INFORMATION — LIST ALL DEPENDENTS YOU WISH TO COVER (attach a separate sheet if necessary)

SOCIAL SECURITY NUMBER	NAME (LAST, FIRST, MI)	BIRTHDATE	GENDER	RELATIONSHIP	ACQUIRE DATE *	HEALTH	DENTAL	VISION
			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

* The acquire date is the date of marriage, birth, adoption or guardianship.
PROOF OF A DEPENDENT'S ELIGIBILITY MUST BE SUBMITTED WITH THIS APPLICATION FOR ALL NEW DEPENDENTS.
 A separate sheet with more dependents is attached

PART 6: RETIREE AUTHORIZATION

I confirm that all of the information above is true. If I choose the Partnership Promise PPO, then I agree to the terms and conditions of the Partnership Promise. I know that I can lose my insurance if I give false information. I may also face disciplinary and legal charges. If my dependents lose eligibility, I know that I must tell Benefits Administration within one calendar month. If I do not, then I will have to pay the plan back for all of my dependent's healthcare bills. Finally, I authorize healthcare providers to give my insurance carrier the medical and insurance records for me and my dependents.

RETIREE SIGNATURE	DATE	HOME PHONE
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Complete in blue or black ink
Completed form must be postmarked or faxed to Benefits Administration by 10/28/16 — Attention: Retirement