RESET

STATE OF TENNESSEE GROUP INSURANCE PROGRAM

DENTAL INSURANCE APPLICATION — COBRA OR RETIREE

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

PARTNERS FOR HEALTH

Complete in blue or black ink.

PART 1: ACTION REQUESTED

PARTICIPANT STATUS	ADD	CHANGE	TERMINATE
❑ COBRA	❑ Coverage: Self	❑ Transfer to Delta Dental DPPO	❑ Coverage: Self
❑ Retiree	❑ Coverage: Spouse	❑ Transfer to Cigna DHMO (Prepaid)	❑ Coverage: Spouse
	❑ Coverage: Child(ren)		❑ Coverage: Child(ren)

PART 2: APPLICANT INFORMATION

LAST NAME	FIRST NAME	MI	SSN OR EDISON ID

DATE OF BIRTH	GENDER	MARITAL STATUS	EMPLOYER/RETIREE GROUP: ❑ UT ❑ TBR ❑ State ❑ Local Ed ❑ Local Gov	DESIRED EFFECTIVE DATE
	❑ M ❑ F			

HOME ADDRESS	CITY	ST	ZIP CODE	COUNTY

PART 3: DENTAL COVERAGE SELECTION

SELECT A PLAN

❑ Delta Dental Dental Preferred Provider Organization (DPPO)

❑ Cigna Dental Health Maintenance Organization — You MUST select a general dentist from the list of participating network dentists

SELECT A DENTAL PREMIUM LEVEL

❑ self only ❑ self + spouse

❑ self + child(ren) ❑ self + spouse + child(ren)

PART 4: 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 *
			❑ M ❑ F		
			❑ M ❑ F		
			❑ M ❑ F		
			❑ M ❑ F		

* 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 5: AUTHORIZATION

I confirm that the information above is true. I understand my dental selection is effective until the end of the plan year (December 31), subject to plan eligibility criteria, and that I cannot change insurance plans or carriers during the plan year. If I experience a qualifying event mid-year, I may be eligible for changes in enrollment of plan members and dependents as a special enrollment. I understand that submission of fraudulent information may lead to consequences including cancellation of insurance or possible criminal penalties. 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 my dependent's claims.

SIGNATURE	DATE	HOME PHONE

EMAIL ADDRESS

DEPENDENT ELIGIBILITY

Definitions and Required Documents

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TYPE OF DEPENDENT	DEFINITION	REQUIRED DOCUMENT(S) FOR VERIFICATION
Spouse	A person to whom the participant is legally married	You will need to provide a document proving marital relationship **AND** one document from the additional documents list below:
		Proof of Marital Relationship • Government-issued marriage certificate or license • Naturalization papers indicating marital status
		Additional Documents • Bank Statement issued within the last six months with both names; **or** • Mortgage Statement issued within the last six months with both names; **or** • Residential Lease Agreement within the current terms with both names; **or** • Credit Card Statement issued within the last six months with both names; **or** • Property Tax Statement issued within the last 12 months with both names; **or** • The first page of most recent Federal Tax Return filed showing "married filing jointly" or "married filing separately" with the name of the spouse provided thereon; submit page 1 of the return with the income figures blacked out
		If just married in the previous 12 months, only a marriage certificate is needed for proof of eligibility
Natural (biological) child under age 26	A natural (biological) child	The child's birth certificate (will accept mother's copy for newborn); **or**
		Certificate of Report of Birth (DS-1350); **or**
		Consular Report of Birth Abroad of a Citizen of the United States of America (FS-240); **or**
		Certification of Birth Abroad (FS-545)
Adopted child under age 26	A child the participant has adopted or is in the process of legally adopting	Final court order granting adoption; **or**
		International adoption papers from country of adoption; **or**
		Court order placing child in custody of member for purpose of adoption
Child under age 26 placed for guardianship, custody or conservatorship with the head of contract* (placement order active or expired due to age of majority)	A child under age 26 for whom the head of contract is or has been the legal guardian, custodian or conservator	Valid order by a court of competent jurisdiction (placement order) establishing guardianship, custody or conservatorship arrangement between child and head of contract; **and** an attestation signed by the head of contract upon initial enrollment and upon request
Stepchild under age 26	A stepchild	Verification of marriage between employee and spouse (as outlined above) **and** birth certificate of the child showing the relationship to the spouse, **or** documents determined by BA to be the legal equivalent
Disabled dependent	A dependent of any age who falls under one of the categories previously listed and due to a mental or physical disability, is unable to earn a living. The dependent's disability must have begun before age 26 and while covered under a state-sponsored plan.	Certificate of Incapacitation for Dependent Child form must be submitted prior to the dependent's 26th birthday. The insurance carrier will review the form, make a determination and provide BA with documentation once a determination has been made. If approved for incapacity, the child will continue the same coverage.

*Head of contract is the person who elects coverage and has authority to change coverage elections.

Never send original documents. Please mark out or black out any Social Security numbers and any personal financial information on the copies of your documents BEFORE you return them.