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	MARITAL STATUS	ARE YOU THE SURVIVING SPOUSE OF A DECEASED RETIREE?	AGENCY RETIRED FROM
	❑ M ❑ F		❑ Yes ❑ No	

HOME ADDRESS	CITY	ST	ZIP CODE	COUNTY

PART 2: HEALTH COVERAGE SELECTION

❑ Add
❑ Change
❑ Cancel

❑ Retiree
❑ Spouse
❑ Child

SELECT A BENEFIT OPTION
❑ Premier PPO
❑ Standard PPO
❑ CDHP/HSA or Local CDHP/HSA
❑ Limited PPO (local education and local government only)

SELECT A CARRIER
❑ BlueCross BlueShield Network S
❑ Cigna LocalPlus
❑ Cigna Open Access (surcharge applies)

SELECT A PREMIUM LEVEL
❑ retiree only
❑ retiree + child(ren)
❑ retiree + spouse
❑ retiree + spouse + child(ren)
❑ spouse ONLY
❑ child(ren) ONLY
❑ spouse + child(ren) ONLY

PART 3: DENTAL COVERAGE SELECTION

❑ Add
❑ Change
❑ Cancel

❑ Retiree
❑ Spouse
❑ Child

SELECT PLAN
❑ MetLife DPPO
❑ Cigna Prepaid DHMO

SELECT A PREMIUM LEVEL
❑ retiree only
❑ retiree + child(ren)
❑ retiree + spouse
❑ retiree + spouse + child(ren)

PART 4: VISION COVERAGE SELECTION (must be on health coverage)

❑ Add
❑ Change
❑ Cancel

❑ Retiree
❑ Spouse
❑ Child

SELECT PLAN
❑ Basic
❑ Expanded

SELECT A PREMIUM LEVEL
❑ retiree only
❑ retiree + child(ren)
❑ retiree + spouse
❑ retiree + spouse + child(ren)
❑ spouse ONLY
❑ child(ren) ONLY
❑ 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
			❑ 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 6: RETIREE AUTHORIZATION

I confirm that all of the information above is true. 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. I understand that I will be responsible for any claims paid in error. 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

Complete in blue or black ink
Completed form must be postmarked or faxed to Benefits Administration by 10/25/19 — Attention: Retirement