RESET

STATE OF TENNESSEE GROUP INSURANCE PROGRAM

RETIREE INSURANCE CHANGE APPLICATION

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

Please complete in blue or black ink and return completed form to Benefits Administration.

PART 1: ACTION REQUESTED — PLEASE SEE PAGE 4 FOR INSTRUCTIONS

TYPE OF ACTION	REASON FOR ACTION		PARTICIPANTS AFFECTED	COVERAGE AFFECTED	EFFECTIVE DATE REQUESTED
❑ Add Coverage	❑ Court Order	Special Qualifying Event (also complete page 3)	❑ Retiree	❑ Health	
❑ Change Coverage	Life Event (also complete page 3)	❑ Death	❑ Spouse	❑ Dental	
❑ Update Personal Info	❑ Marriage	❑ Divorce	❑ Child(ren)	❑ Vision	
Form not for cancellation	❑ Newborn/Adoption	❑ Loss of Eligibility			
	❑ Legal Guardianship				

PART 2: RETIREE INFORMATION

FIRST NAME	MI	LAST NAME	DATE OF BIRTH	GENDER	MARITAL STATUS
				❑ M ❑ F	❑ S ❑ M ❑ D ❑ W

SOCIAL SECURITY NUMBER	ELIGIBLE FOR MEDICARE?	IF YES, MEDICARE PART A EFFECTIVE DATE	MEDICARE PART B EFFECTIVE DATE
	❑ Yes ❑ No		

HOME ADDRESS ❑ UPDATE MY ADDRESS	CITY	ST	ZIP CODE	COUNTY

PART 3: HEALTH COVERAGE SELECTION — Choose carefully. Except for qualifying events, changes are not allowed outside this plan's annual enrollment.

BENEFIT OPTION	CARRIER	REGION WHERE YOU LIVE	HEALTH PREMIUM LEVEL	
❑ Standard PPO	❑ BlueCross BlueShield (Network S)	❑ East	❑ retiree only	❑ spouse only
❑ Premier PPO	❑ Cigna (LocalPlus)	❑ Middle	❑ retiree + spouse + child(ren)	❑ child(ren) only
❑ Limited PPO (local ed/local gov only)	❑ Cigna Open Access (surcharge applies)	❑ West	❑ retiree + spouse	❑ spouse + child(ren)
❑ CDHP/HSA		See page 4 for map and information for out-of-state residents	❑ retiree + child(ren)	
❑ Local CDHP/HSA (local ed/local gov only)				

PART 4: DENTAL COVERAGE

PLAN	CHECK ALL THAT APPLY (Retiree must be TCRS or Higher Ed ORP participant)		
❑ MetLife DPPO	❑ retiree	❑ spouse	❑ child(ren)
❑ CignaPrepaid DHMO			

PART 5: VISION COVERAGE

PLAN	CHECK ALL THAT APPLY (must be enrolled in group health)		
❑ Basic	❑ retiree	❑ spouse	❑ child(ren)
❑ Expanded			

PART 6: DEPENDENT INFORMATION — attach a separate sheet if necessary

NAME (FIRST, MI, LAST)	DATE OF BIRTH	RELATIONSHIP	GENDER	SOCIAL SECURITY NUMBER	MEDICARE ELIGIBLE	
			❑ M ❑ F		PART A ❑ Y ❑ N	DATE EFFECTIVE
			❑ M ❑ F		PART A ❑ Y ❑ N	DATE EFFECTIVE
			❑ M ❑ F		PART A ❑ Y ❑ N	DATE EFFECTIVE

Proof of a dependent's eligibility must be submitted with this application for all new dependents (see page 2). ❑ A SEPARATE SHEET WITH MORE DEPENDENTS IS ATTACHED

PART 7: AUTHORIZATION

I confirm that the information above is true. I understand my health, dental and vision selections are 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 healthcare bills.

SIGNATURE	DATE	HOME PHONE

EMAIL ADDRESS	AGENCY RETIRED FROM

Dependent Eligibility
Definitions and Required Documents

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 Stat**e**ment 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; **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 for whom the participant is legal guardian	A child for whom the participant is the legal guardian	Court order making member a guardian of another and stating the length of the guardianship
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
Child for whom the plan has received a qualified medical child support order	A child who is named as an alternate recipient with respect to the participant under a qualified medical child support order (QMCSO)	Court documents signed by a judge; **or**
		Medical support orders issued by a state agency
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.

Revised 7/20

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.

NAME	EDISON ID	OR	SSN

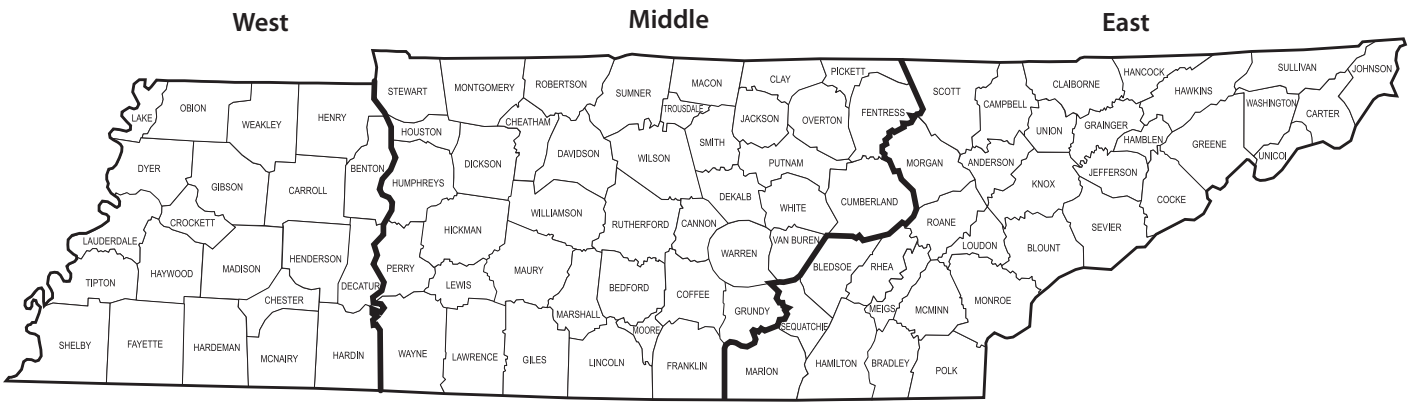
Special Enrollment Qualifying Events

The federal law, Health Insurance Portability and Accountability Act (HIPAA), allows you and your dependents to enroll in health coverage under certain conditions, including acquiring new dependents and loss of health coverage offered through your spouse's or ex-spouse's employer. If you are adding dependents to your **existing** coverage, you and your dependents may transfer to a different carrier or healthcare option, if eligible. You or your dependents may also be eligible to enroll in dental and vision coverage when dental and vision coverage is lost with another employer. Premiums are not prorated. If approved, you must pay premium for the entire month in which the effective date occurs.

INSTRUCTIONS: Identify the qualifying event(s) which apply to you and/or your eligible dependent(s). You must submit this page with the appropriate required documentation, proof of prior coverage and a completed enrollment application. **NOTE: Application for enrollment must be made within 60 days of the loss of insurance coverage or within 60 days of a new dependent's acquire date. Voluntary actions resulting in loss of coverage (such as voluntary cancellation of coverage and cancellation for not paying premiums) ARE NOT qualifying events. Electing to cancel, waive or decline coverage during another plan's enrollment period IS NOT a qualifying event.**

QUALIFYING EVENT	DOCUMENTATION REQUIRED	EFFECTIVE DATE
☐ Death of spouse or ex-spouse	Copy of death certification and written documentation from the employer on company letterhead providing names of covered participants and date coverage ended	Day after loss of coverage **OR** first day of the month following loss of other coverage
☐ Divorce	Copy of the signed divorce decree and written documentation from the employer on company letterhead providing names of covered participants, date coverage ended and what coverage was lost (i.e., medical, dental, vision)	Day after loss of coverage **OR** first day of the month following loss of other coverage
☐ Legal separation	Copy of the agreed order of legal separation and written documentation from the employer on company letterhead providing names of covered participants, date coverage ended, reason why coverage ended and what coverage was lost (i.e., medical, dental, vision)	Day after loss of coverage **OR** first day of the month following loss of other coverage
☐ Loss of eligibility (does not include a loss due to failure to pay premiums or termination of coverage for cause)	Written documentation from the employer or the insurance company on company letterhead providing the names of covered participants, date coverage ended, reason for the loss of eligibility and what coverage was lost (i.e., medical, dental, vision)	Day after loss of coverage **OR** first day of the month following loss of other coverage
☐ Loss of coverage due to exhausting lifetime benefit maximum	Written documentation from the insurance company on company letterhead providing the names of covered participants, date coverage ended, stating that the lifetime maximum has been met and what coverage was lost (i.e., medical, dental, vision)	Day after loss of coverage **OR** first day of the month following loss of other coverage
☐ Loss of TennCare (does not include a loss due to failure to pay premiums)	Written documentation from TennCare providing the names of covered participants, date coverage ended and the reason why coverage ended	Day after loss of coverage **OR** first day of the month following loss of other coverage
☐ Termination of spouse's or ex-spouse's employment (voluntary and non-voluntary)	Written documentation from the employer on company letterhead providing names of covered participants, date coverage ended, reason why coverage ended and what coverage was lost (i.e., medical, dental, vision)	Day after loss of coverage **OR** first day of the month following loss of other coverage
☐ Employer eliminated contribution to spouse's, ex-spouse's or dependent's insurance coverage (total contribution, not partial)	Written documentation from the employer on company letterhead providing names of covered participants, date contribution amount changed, date coverage ended and what coverage was lost (i.e., medical, dental, vision)	Day after loss of coverage **OR** first day of the month following loss of other coverage
☐ Spouse's or ex-spouse's work hours reduced causing loss of eligibility for insurance coverage	Written documentation from the employer on company letterhead providing names of covered participants, date coverage ended, reason why coverage ended and what coverage was lost (i.e., medical, dental, vision)	Day after loss of coverage **OR** first day of the month following loss of other coverage
When a new dependent is acquired, a non-covered employee may use the event to enroll in employee only or family coverage. If the employee is already enrolled, they may add the new dependent and previously eligible dependents (those who were not enrolled when initially eligible and are otherwise still eligible). Required documentation is listed below. Employees only requesting to add a new dependent should follow regular enrollment procedures.		
☐ Acquires a new dependent — spouse	Copy of marriage certificate	Date of marriage **OR** first day of the month following marriage
☐ Acquires a new dependent — newborn	Copy of birth certificate for newborn	Date of birth
☐ Acquires a new dependent — adoption/ legal custody	Copy of adoption documents	Date of adoption or legal custody

Counties and Regions For Health Plans



Out of state residents: If you do not live in Tennessee, you will be eligible to enroll in the middle region options.

INSTRUCTIONS

Please complete the entire form and do not leave anything blank. Leaving a section blank can cause a delay in processing your request.

TYPE OF ACTION – mark the box indicating that you want to add or change coverage or update personal information.

COVERAGE AFFECTED – mark all that apply.

PARTICIPANTS AFFECTED – mark all that apply.

Please make sure the rest of the form is filled out completely and be sure to sign and date the form. All supporting dependent verification and proof of special enrollment event must be returned with this application.

Anti-Discrimination and Civil Rights Compliance

Benefits Administration does not support any practice that excludes participation in programs or denies the benefits of such programs on the basis of race, color, national origin, sex, age or disability in its health programs and activities. If you have a complaint regarding discrimination, please call 615-532-9617.

If you think you have been treated in a different way for these reasons, please mail this information to the Civil Rights Coordinator for the Department of Finance and Administration:

- Your name, address and phone number. You must sign your name. (If you write for someone else, include your name, address, phone number and how you are related to that person, for instance wife, lawyer or friend.)
- The name and address of the program you think treated you in a different way.
- How, why and when you think you were treated in a different way.
- Any other key details.

Mail to: State of Tennessee, Civil Rights Coordinator, Department of Finance and Administration, Office of General Counsel, 20th Floor, 312 Rosa L. Parks Avenue, William R. Snodgrass Tennessee Tower, Nashville, TN 37243.

Need free language help? Have a disability and need free help or an auxiliary aid or service, for instance Braille or large print? Please call 615-532-9617.

You may also contact the: U.S. Department of Health & Human Services – Region IV Office for Civil Rights, Sam Nunn Atlanta Federal Center, Suite 16T70, 61 Forsyth Street, SW, Atlanta, Georgia 30303-8909 or 1-800-368-1019 or TTY/TDD at 1-800-537-7697 **OR** U. S. Office for Civil Rights, Office of Justice Programs, U. S. Department of Justice, 810 7th Street, NW, Washington, DC 20531 **OR** Tennessee Human Rights Commission, 312 Rosa Parks Avenue, 23rd Floor, William R. Snodgrass Tennessee Tower, Nashville, TN 37243.

If you speak a language other than English, help in your language is available for free.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-576-0029 (TTY: 1-800-848-0298).

866 (رقم -576-0029- ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1.(800-848-0298- هاتف الصم والبكم: 1

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-866-576-0029 (TTY:1-800-848-0298)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành chobạn. Gọi số 1-866-576-0029 (TTY:1-800-848-0298).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-576-0029 (TTY: 1-800-848-0298) 번으로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-576-0029 (ATS : 1-800-848-0298).

Ni songen mwohmw ohte, komw pahn sohte anahne kawehwe mesen nting me koatoantoal kan ahpw wasa me ntingie [Lokaiahn Pohnpei] komw kalangan oh ntingidieng ni lokaiahn Pohnpei. Call 1-866-576-0029 (TTY: 1-800-848-0298).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለውቁጥር ይደውሉ 1-866-576-0029 (መስማት ለተሳናቸው: 1-800-848-0298).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-576-0029 (TTY: 1-800-848-0298).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-866-576-0029 (TTY:1-800-848-0298)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-866-576-0029（TTY:1-800-848-0298）まで、お電話にてご連絡ください。

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-576-0029 (TTY: 1-800-848-0298).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध है। 1-866-576-0029 (TTY: 1-800-848-0298) पर कॉल करें।

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-576-0029 (телетайп: 1-800-848-0298).

توجه: اگر هب زبان فارسی گفتگو می کنید، تسهیالت زبانی بصورت رایگان برای شما 866-576-0029 (TTY: 1-800-848-0298) فراهم می باشد. با تماس بگیرید