Reset

STATE OF TENNESSEE GROUP INSURANCE PROGRAM

APPLICATION TO CONTINUE INSURANCE AT RETIREMENT

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

You must apply to continue coverage at retirement within one full calendar month of the date active coverage ends. Please complete in blue or black ink and return completed form to Benefits Administration. **See page 3 for detailed instructions on each part of this form.**

PART 1: ACTION REQUESTED

TYPE OF ACTION	REASON FOR ACTION	PARTICIPANTS AFFECTED	COVERAGE AFFECTED	AGENCY RETIRED FROM	
❑ Add Coverage	❑ New Retiree	❑ Retiree	❑ Health		
❑ Update Personal Info	❑ Surviving Dependent Continuing Coverage	❑ Spouse	❑ Dental	ORIGINAL HIRE DATE	TERMINATION DATE
		❑ Child(ren)	❑ Vision	DATE OF RETIREMENT	
			❑ The Tenn Plan		

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: GROUP HEALTH COVERAGE CONTINUATION

CHECK ALL THAT APPLY

❑ retiree ❑ spouse ❑ child(ren)

PART 4: THE TENN PLAN ENROLLMENT

CHECK DESIRED COVERAGE LEVEL

❑ retiree ❑ retiree + spouse
❑ retiree + children ❑ retiree + spouse + child(ren)

PART 5: DENTAL COVERAGE

PLAN	CHECK DESIRED COVERAGE LEVEL	
❑ Delta Dental DPPO	❑ retiree	❑ retiree + spouse
❑ Cigna DHMO	❑ retiree + child(ren)	❑ retiree + spouse + child(ren)

PART 6: VISION COVERAGE

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

PART 7: 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 8: 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 I 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 I must apply to continue coverage within one calendar month of the date my active coverage ends. 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. I have read and understand the information and eligibility criteria on page three.

SIGNATURE	DATE	HOME PHONE	EMAIL ADDRESS

PART 9: EMPLOYER CERTIFICATION — MUST BE COMPLETED BY YOUR AGENCY

EDISON ID			PREMIUM: ❑ RET ❑ INS ❑ BIL	TYPE: ❑ ST ❑ LE ❑ LE-SS ❑ LG
RETIREE IS: ❑ TCRS ❑ NON-TCRS ❑ ORP/TIAA ❑ FRM LEGIS				
ACTIVE CVG TERM DATE	RET CVG EFFECT DATE	YEARS OF CREDITABLE SVC	LENGTH OF PARTICIPATION IN THE PLAN IMMEDIATELY PRIOR TO TERMINATION OF EMPLOYMENT: ❑ 3 OR MORE YEARS ❑ 1-3 YEARS ❑ LESS THAN 1 YEAR	

NAME OF AGENCY	AGENCY SIGNATURE	DATE	PHONE NUMBER

DEPENDENT ELIGIBILITY

Definitions and Required Documents

PARTNERS FOR HEALTH

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.

Instructions

Members who meet the eligibility rules to continue health insurance at retirement for themselves or covered eligible dependents must submit an application within one full calendar month of the date active coverage ends. If you do not submit the paperwork within this time frame the only way you can later enroll in the retirement plan would be to meet the special qualifying event criteria.

PART 1: This section should be completely filled out by the retiree and separating agency. The original hire date is with the qualifying agency. For TCRS members, the date of retirement is the effective date of your retirement with the Tennessee Consolidated Retirement System. The termination date of employment is either the last day in an active paid status or the last day of an approved leave of absence, whichever is later. This date must be confirmed by your separating agency and is certified by your agency benefit coordinator signing the employer certification section of this form.

PART 2 RETIREE INFORMATION: This section must completed by the retiree. If you are a surviving spouse who is continuing coverage as the new head of contract on the retiree plan, please complete the application with your information as the retiree. If you are entitled to Medicare you must submit a copy of your Medicare card with this application.

PART 3 GROUP HEALTH: Eligibility requirements to continue group health coverage for retirees and their dependents are outlined in Section 4 of the State, Local Education and Local Government Plan Documents. The plan documents can be viewed at https://www.tn.gov/partnersforhealth/publications/publications.html.

As outlined in Section 4 of the State and Local Education Plan Documents, retirees and dependents who become entitled to Medicare Part A prior to the age of 65, must enroll in Part B in order to maintain group health coverage until entitled to Medicare by virtue of age. Copies of Medicare cards must be submitted to Benefits Administration as documentation of enrollment in Medicare Parts A and B. If the pre 65 Medicare entitled retiree or retiree dependent does not enroll in Medicare Part B when eligible, coverage under the state group health plan will be terminated.

LOCAL GOVERNMENT retirees and dependents who become entitled to Medicare Part A are NOT eligible for coverage under the retiree group health plan as referenced in Section 4 of the Local Government plan document.

In all cases, it is the responsibility of the retiree to notify Benefits Administration within 5 working days if the retiree or a covered dependent has become eligible for Medicare prior to the age of 65.

PART 4 THE TENNESSEE PLAN: To be eligible for The Tennessee Plan, supplemental medical insurance for retirees with Medicare, your original hire date of employment with a TCRS or ORP agency must have been prior to July 1, 2015; you must be receiving a monthly TCRS pension or be a Higher Education ORP retiree and you (the retiree) and the dependent(s) you wish to cover must be enrolled in at least Medicare Part A. You must submit a copy of your Medicare card(s) with this application. If you are only enrolled in Medicare Part A, The Tenn Plan will pay after Medicare for Part A expenses and will pay for Medicare Part B expenses after estimating the amount Medicare Part B would have paid. In addition, The Tenn Plan will not pay or coordinate benefits if you are enrolled in a Medicare HMO or Medicare Advantage plan. The Tenn Plan does not offer any pharmacy benefits. You must enroll in Medicare Part D or subscribe to another supplemental for pharmacy needs. If you are enrolled in TennCare, you do not need supplemental coverage to Medicare. This enrollment form must be completed within 60 days of your initial eligibility which is either the date you become eligible for Medicare, your date of retirement or the effective date of loss of creditable group health coverage; whichever is later.

If you are applying 60 days or more past your initial eligibility date, you must apply as a late applicant and enrollment will be subject to approval. If you are a late applicant, please contact Benefits Administration for The Tenn Plan late applicant information.

PART 5 DENTAL: To be eligible to apply for retiree dental you MUST receive a monthly TCRS pension or be a higher education ORP retiree. If you do not apply within one full calendar month of your active group health insurance and/or dental benefits termination the effective date of your coverage will be the first of the following month in which you apply. If you select the DHMO (Prepaid Provider) dental plan, please note that you MUST select a dentist who participates in the network. The DHMO plan will not pay any benefits if you do not select and use a participating network general dentist. Once your coverage has changed from active to retiree you MUST contact the carrier to confirm your continued use of your selected participating network general dentist. Additional information on retiree dental and COBRA dental can be obtained from your agency benefits coordinator or viewed at tn.gov/partnersforhealth.html.

PART 6 VISION: To be eligible to apply for vision you MUST receive a monthly TCRS pension or be a higher education ORP retiree and be enrolled in the state's group health insurance plan.

PART 7 DEPENDENT INFORMATION: This section must be completed if you are applying to cover a dependent. You must complete the Medicare eligibility information in this section and submit a copy of your dependent's Medicare card. If you have not previously submitted dependent verification documentation on a dependent you are applying to cover, please submit the applicable documentation with this application as outlined on page 2.

PART 8 RETIREE AUTHORIZATION: This section must be signed and dated by the retiree (or surviving spouse if they are the new head of contract). If the retiree has a designated power of attorney, a copy of the POA must be attached to this application.

PART 9 EMPLOYER CERTIFICATION: The designated official with the separating agency must complete and certify if the retiree is a TCRS member, a non-TCRS retiree, a higher education ORP retiree or a former legislator. The correct premium collection method should also be designated:

- RET = premiums will be collected from the TCRS pension check
- INS = Benefits Administration has agreed to bill the agency for retiree premiums
- BIL = the retiree will be billed directly at home by Benefits Administration

Type of retiree must also be completed:

- ST = State
- LE = Local Education teacher/certified staff
- LE-SS = Local Education support staff
- LG = Local Government

Active coverage term date indicates the date an active employee's insurance is terminated. Years of creditable service must be certified by agency for non-TCRS, ORP and former legislators. The agency should also review and mark on the form the applicable time frame the retiree has been continuously covered on the plan immediately preceding termination of employment. The form must be signed and dated by the designated agency official. By signing the employer certification section the agency is also certifying the correct term date of employment and date of retirement has been completed in Part 1.

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