STATE OF TENNESSEE GROUP INSURANCE PROGRAM

THE TENNESSEE PLAN (SUPPLEMENTAL MEDICAL INSURANCE FOR RETIREES WITH MEDICARE) ENROLLMENT 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

PART 1: ACTION REQUESTED

TYPE OF ACTION

- ☐ Add Coverage
- ☐ Change Coverage
- ☐ Update Personal Info

REASON FOR ACTION

- ☐ Newly Eligible Retiree
- ☐ Late Applicant
- ☐ Surviving Spouse Continuing Coverage
- ☐ Loss of Creditable Group Health Coverage (see page 3)
- ☐ Add Medicare eligible dependent

AGENCY RETIRED FROM

DATE OF RETIREMENT

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: COVERAGE REQUESTED — must submit a copy of your Medicare card with this application

I am applying to cover the following eligible participants in the TN Plan (Supplemental Medical to Medicare) (check all to be covered)

- ☐ retiree
- ☐ retiree + spouse
- ☐ retiree + child(ren)
- ☐ retiree + spouse + child(ren)

☐ I am applying for coverage for myself or one of my dependents 60 days or more past the initial eligibility date as a late applicant (you must also complete page 2)

PART 4A: SPOUSE INFORMATION

FIRST NAME	MI	LAST NAME	DATE OF BIRTH	GENDER	DATE OF MARRIAGE
				☐ M ☐ F	

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

PART 4B: DEPENDENT CHILD INFORMATION

FIRST NAME	MI	LAST NAME	DATE OF BIRTH	GENDER	ACQUIRE DATE
				☐ M ☐ F	

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

PART 5: 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 notify 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. I authorize healthcare providers to give my insurance carrier the medical and insurance records for me and my dependents. I understand I must submit a copy of my Medicare card for myself and any covered dependents. I have read and understand the information and eligibility criteria on page 3.

SIGNATURE	DATE	HOME PHONE	EMAIL ADDRESS

PART 6: INDICATE YOUR RETIREMENT TYPE

- ☐ I receive a monthly pension from the Tennessee Consolidated Retirement System (TCRS)
- ☐ I am the surviving spouse of a TCRS retiree and I will receive a monthly survivors pension from TCRS
- ☐ I am the surviving spouse of a TCRS retiree and I will NOT receive a monthly survivors pension from TCRS
- ☐ I am an Optional Retirement Plan (ORP) retiree from the University of Tennessee (UT) or a Tennessee Board of Regents (TBR) College
- ☐ I am the surviving spouse of a UT/TBR ORP retiree

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

NAME	EMPLOYEE ID	OR	SSN

The Tennessee Plan (SUPPLEMENTAL MEDICAL INSURANCE FOR RETIREES WITH MEDICARE) LATE APPLICANTS ONLY

The following information must be supplied if you are applying for coverage 60 days or more past your initial eligibility date.

You do not have to complete this questionnaire if you are applying within 60 days of your initial eligibility date.

RETIREE INFORMATION			
YES	NO	DO YOU NOW HAVE OR HAVE YOU HAD IN THE LAST FIVE YEARS ANY OF THE FOLLOWING:	
☐	☐	Heart attack	If yes, when:
☐	☐	Cancer (not skin cancer)	If yes, when:
☐	☐	Stroke	If yes, when:
☐	☐	Kidney failure	If yes, when:

SPOUSE INFORMATION (IF APPLYING)			
YES	NO	DO YOU NOW HAVE OR HAVE YOU HAD IN THE LAST FIVE YEARS ANY OF THE FOLLOWING:	
☐	☐	Heart attack	If yes, when:
☐	☐	Cancer (not skin cancer)	If yes, when:
☐	☐	Stroke	If yes, when:
☐	☐	Kidney failure	If yes, when:

DEPENDENT CHILD INFORMATION (IF APPLYING)			
YES	NO	DO YOU NOW HAVE OR HAVE YOU HAD IN THE LAST FIVE YEARS ANY OF THE FOLLOWING:	
☐	☐	Heart attack	If yes, when:
☐	☐	Cancer (not skin cancer)	If yes, when:
☐	☐	Stroke	If yes, when:
☐	☐	Kidney failure	If yes, when:

I confirm that all of the information provided is accurate. I authorize healthcare providers to furnish the insurance carrier with all medical, admission and insurance records pertaining to me and my dependents. I understand that if my dependents become ineligible for coverage that I must report the change to my retirement plan within five working days. I understand that all claims paid for ineligible dependents must be repaid to the plan by me. I have submitted proof of being enrolled in Medicare Part A and B.

Retiree signature _____ Date _____

Spouse signature (if applying) _____ Date _____

Dependent child signature (if applying) _____ Date _____

Or signature of guardian/legal representative if dependent child is a minor

_____ Date _____

Relationship to dependent child _____

Instructions

PART 1 REASON FOR ACTION: If you are applying due to a loss other creditable group health coverage that is not under the state of Tennessee's group health plans you must provide documentation from the former plan. The documentation must be from the employer or insurance company on company letterhead providing the names of covered participants, date coverage ended and the reason why coverage ended.

PART 2 RETIREE INFORMATION: This section must be 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. You must submit a copy of your Medicare card with this application.

PART 3 COVERAGE REQUESTED: To be eligible for the TN Plan (Supplemental Medical Insurance for Retirees with Medicare) certificate, you must receive a monthly TCRS or Higher Education ORP retirement benefit and your initial employment with the state or other qualifying employer must have commenced prior to July 1, 2015. You and the dependent you wish to cover must be enrolled in at least Medicare Part A. The only exception to the requirement to receive a monthly TCRS or ORP benefit is for surviving spouses who were covered on the TN Plan at the time of the retiree's death and are applying to continue that coverage as the new head of contract. You must submit a copy of your Medicare card with this application. The TN Plan will not pay if you are not enrolled in Medicare. If you only enroll in Medicare Part A, the TN Plan will pay after Medicare for Part A expenses but will not pay for Medicare Part B expenses. In addition, the TN Plan will not pay behind or coordinate benefits if you have enrolled in a Medicare HMO or Medicare Advantage plan. The TN 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 Medicare supplement coverage. This enrollment form must be completed within 60 days of 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. To apply as a late applicant you must complete the applicable sections of pages 1 and 2 and submit application to Benefits Administration. Benefits Administration will forward late applicants to the TN Plan (Supplemental Medical Insurance for Retirees with Medicare) vendor for review. You will be notified directly by the vendor of the approval status of the application.

PART 4 DEPENDENT INFORMATION: This section must be completed if you are applying to cover a dependent on any of the state insurance benefits. Please note that if you are applying to cover a dependent, you must also complete their Medicare eligibility information in this section and submit a copy of their Medicare card if they are Medicare entitled.

PART 5 RETIREE AUTHORIZATION: This section must be signed and dated by the retiree (or surviving spouse if the new head of contract due to retiree death). If you have a designated Power of Attorney, a copy of the POA must be attached to 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 1-866-576-0029.

If you think you have been treated in a different way for these reasons, please mail this information to Benefits 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, Benefits Administration, Civil Rights Compliance, Department of Finance and Administration, 19th Floor, 312 Rosa L. Parks Avenue, William R. Snodgrass Tennessee Tower, Nashville, TN 37243-1102.

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 1-866-576-0029.

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

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 ሚከተለው

ቁጥር 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 हैं। 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 به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما 866-576-0029 (TTY: 1-800-848-0298) فراهم می باشد. با تماس بگیرید.