



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



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

| PART 1: ACTION REQUESTED — PLEASE SEE PAGE 3 FOR INSTRUCTIONS | | | | | | |
|---|--|--|---|--|---|---------------------------------|
| TYPE OF ACTION <input type="checkbox"/> Add Coverage <input type="checkbox"/> Change Coverage <input type="checkbox"/> Update Personal Info Form not for cancellation | REASON FOR ACTION <input type="checkbox"/> Court Order Qualifying Event (also complete page 3) <input type="checkbox"/> Marriage <input type="checkbox"/> Newborn/Adoption | | <input type="checkbox"/> Legal Guardianship <input type="checkbox"/> Death <input type="checkbox"/> Divorce <input type="checkbox"/> Loss of Eligibility | PARTICIPANTS AFFECTED <input type="checkbox"/> Retiree <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) | COVERAGE AFFECTED <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision | EFFECTIVE DATE REQUESTED |

| PART 2: RETIREE INFORMATION | | | | | |
|-----------------------------|--|--|---------------|---|---|
| FIRST NAME | MI | LAST NAME | DATE OF BIRTH | GENDER <input type="checkbox"/> M <input type="checkbox"/> F | MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W |
| SOCIAL SECURITY NUMBER | ELIGIBLE FOR MEDICARE? <input type="checkbox"/> Yes <input type="checkbox"/> No | IF YES, MEDICARE PART A EFFECTIVE DATE | | MEDICARE PART B EFFECTIVE DATE | |
| HOME ADDRESS | <input type="checkbox"/> 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 <input type="checkbox"/> Standard PPO <input type="checkbox"/> Premier PPO <input type="checkbox"/> Limited PPO (local ed/local gov only) <input type="checkbox"/> CDHP/HSA (state/higher ed only) <input type="checkbox"/> Local CDHP/HSA (local ed/local gov only) | CARRIER & NETWORK <input type="checkbox"/> BCBS Network S <input type="checkbox"/> BCBS Network P* <input type="checkbox"/> Cigna LocalPlus <input type="checkbox"/> Cigna Open Access* *higher premium applies | HEALTH PREMIUM LEVEL <input type="checkbox"/> retiree only <input type="checkbox"/> retiree + spouse + child(ren) <input type="checkbox"/> retiree + spouse <input type="checkbox"/> retiree + child(ren) <input type="checkbox"/> spouse only <input type="checkbox"/> child(ren) only <input type="checkbox"/> spouse + child(ren) |

| PART 4: DENTAL COVERAGE | | PART 5: VISION COVERAGE | |
|--|--|--|--|
| PLAN <input type="checkbox"/> Delta Dental DPPO <input type="checkbox"/> Cigna DHMO (Prepaid Provider) | CHECK ALL THAT APPLY (Retiree must be TCRS or Higher Ed ORP participant) <input type="checkbox"/> retiree <input type="checkbox"/> spouse <input type="checkbox"/> child(ren) | PLAN <input type="checkbox"/> Basic <input type="checkbox"/> Expanded | CHECK ALL THAT APPLY (must be enrolled in group health) <input type="checkbox"/> retiree <input type="checkbox"/> spouse <input type="checkbox"/> child(ren) |

| PART 6: DEPENDENT INFORMATION — attach a separate sheet if necessary | | | | | | |
|--|---------------|--------------|---|------------------------|--|----------------|
| NAME (FIRST, MI, LAST) | DATE OF BIRTH | RELATIONSHIP | GENDER | SOCIAL SECURITY NUMBER | MEDICARE ELIGIBLE | |
| | | | <input type="checkbox"/> M <input type="checkbox"/> F | | PART A <input type="checkbox"/> Y <input type="checkbox"/> N | DATE EFFECTIVE |
| | | | <input type="checkbox"/> M <input type="checkbox"/> F | | PART A <input type="checkbox"/> Y <input type="checkbox"/> N | DATE EFFECTIVE |
| | | | <input type="checkbox"/> M <input type="checkbox"/> F | | PART A <input type="checkbox"/> Y <input type="checkbox"/> 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, I may be eligible for changes in enrollment of plan members and dependents. 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 be responsible for any claims paid in error. | | |
| SIGNATURE | DATE | HOME PHONE |
| EMAIL ADDRESS | AGENCY RETIRED FROM | |



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 <ul style="list-style-type: none"> • Government-issued marriage certificate or license • Naturalization papers indicating marital status |
| | | Additional Documents <ul style="list-style-type: none"> • 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 |
| 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 child 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. | <p>Certificate of Incapacitation for Dependent Child form must be submitted prior to the dependent’s 26th birthday. Additional documentation will be required to comply with any future review.</p> <p>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.</p> |
| 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 |

*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.

| | | | |
|------|-----------|-----------|-----|
| NAME | EDISON ID | OR | SSN |
|------|-----------|-----------|-----|

Qualifying Events

If you or a dependent lose coverage under any other group insurance plan, or if you acquire a new dependent during the plan year, you and eligible dependents may have additional opportunities to enroll in health coverage. If you are adding dependents to your **existing** coverage, you and eligible dependents may transfer to a different carrier or healthcare option, if eligible. You or eligible dependents may also be eligible to enroll in dental and vision coverage if you meet the requirements stated in the dental or vision certificates of coverage. Premiums are not prorated. If approved, you must pay the required premium for the entire month in which the effective date occurs.

INSTRUCTIONS: Identify the qualifying event(s) which applies to you 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 eligibility for other health insurance coverage or within 30 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.

Retroactive coverage (a coverage effective date that begins before an enrollment is completed and submitted to BA) **is not allowed except for birth, adoption and placement for adoption.** For all other events, the earliest effective date allowed for coverage under this plan is the first day of the month following the date that your enrollment request, including all required documentation, is completed and submitted to BA. Enrollment should be completed and submitted to BA as soon as possible to ensure the earliest possible effective date. The examples provided below assume all eligibility requirements are satisfied and that required documentation is submitted with enrollment.

EXAMPLE 1

Marriage date is June 15 (30- day enrollment period applies):

- enrollment submitted to BA on June 25 = 7/1 effective date
- enrollment submitted to BA on July 10 = 8/1 effective date
- enrollment submitted on or after July 16 will exceed the 30-day enrollment period, and your request will be denied

EXAMPLE 2

Loss of other coverage date is June 30 (60-day enrollment period applies):

- enrollment submitted to BA on June 30 = 7/1 effective date
- enrollment submitted to BA on July 10 = 8/1 effective date
- enrollment submitted to BA on August 5 = 9/1 effective date
- enrollment submitted on or after August 30 will exceed the 60-day enrollment period, and your request will be denied

| QUALIFYING EVENT | EFFECTIVE DATE | DOCUMENTATION REQUIRED |
|---|---|--|
| <input type="checkbox"/> An event causing the loss of eligibility for coverage from another group health insurance plan* | The effective date is the first day of the first calendar month after the date BA receives the request for special enrollment | Written documentation from an employer, former employer, insurance company, or former insurance company on company letterhead that lists (1) names of covered participants; (2) dates of coverage including your coverage at the time coverage in this plan was declined; (3) types of coverage (medical, dental, vision); (4) each participant that lost eligibility for coverage; (5) the date of loss of eligibility to continue coverage, and (6) the reason why eligibility for coverage was lost |
| <input type="checkbox"/> An event that results in acquisition of a new dependent spouse or stepchild acquired by marriage, or a child acquired pursuant to an order of guardianship** | The effective date is the first day of the first calendar month after the date BA receives the request for special enrollment | 1. Marriage Certificate 2. Birth Certificate (will accept mother's copy for newborn) 3. Order of Guardianship requiring financial support and provision of insurance coverage, which sets out the date of the guardianship period |
| <input type="checkbox"/> An event that results in acquisition of a new dependent acquired by birth, adoption, or placement in legal custody for adoption** | The effective date is the date of birth, adoption, or placement for adoption | 1. Birth Certificate (will accept mother's copy for newborn) 2. Final Order of Adoption or Order of Custody in anticipation of adoption |

* When eligibility for coverage under other insurance is lost, only the retiree and any dependents who lose the other coverage may enroll.

** When a new dependent is acquired, a retiree may enroll in retiree only or family coverage and may add the new dependent and previously eligible dependents (those who were not enrolled when initially eligible and are otherwise still eligible).

The retiree and dependents may only enroll in the types of coverage lost (medical/medical; dental/dental; vision/vision).

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

As required by law, a Summary of Benefits and Coverage is available which describes your 2024 health coverage options. The SBC may be found at www.tn.gov/ParTNersForHealth/summary-of-benefits-and-coverage no later than Sept. 1. The digital newsletter contains much of the same information. To get a SBC paper copy, free of charge, call 855.809.0071. Please include your name, complete mailing address and name of the SBCs you want: State and Higher Education Plan; Local Education Plan; or Local Government Plan.

The Plans are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to PHI. Find Notice of Privacy Practice and other important Legal Notices including Prescription Drug Coverage and Medicare and more at https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/legal_notices.pdf

Find the Notice Regarding Wellness Program at tn.gov/ParTNersForHealth under Wellness, or email benefits.info@tn.gov to request a mailed copy of the Wellness Program Notice.

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, contact the Finance and Administration Civil Rights Coordinator at FA.CivilRights@tn.gov or 615-532-9617.

Have you been denied services or treated differently for the above stated reasons? Find the Department of Finance and Administration's Nondiscrimination Policy and Complaint Procedures and Form under F&A Department Policies at <https://www.tn.gov/finance/looking-for/policies.html> (Policy 36); contact the F&A Civil Rights Coordinator; or mail a complaint to F&A Civil Rights Coordinator/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 such as braille or large print? If you speak a language other than English, help in your language is available for free. Contact the F&A Civil Rights Coordinator at 615-532-9617.

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

مصلحاه 866 (800-848-0298) 1. مقرر لاصتاج ملاب كل رفاوتت ةىوغلل ادعاسملا تامدخ نإف، ةغلل ركذا ثدحتت تنك اذا: ةظوحلم -576-0029 مقرر) 1 مكبلاو

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 cho bạn. 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 kalan- gan 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 ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 1-866-576-0029 (ሞስማት 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).

सुचना: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક 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。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 हंदी 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).

هوجوت: 866-576-0029 (TTY: 1-800-848-0298) دىرىگب سامت هرامش نى اب. دشابىم مهارف امش ىارب ناگىار تروصب ىنابز تالاهست، دىنكىم وگتفگ ىسراف نابز هب رگا: هوجوت 1-800-848-0298

If you have questions about civil rights compliance or concerns, you may also contact:

- 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, GA 30303-8909 or 1-800-368-1019 or TTY/TDD at 1-800-537-7697.
- U.S. Office for Civil Rights, Office of Justice Programs, U.S. Department of Justice, 810 7th Street, NW, Washington, DC 20531.
- Tennessee Human Rights Commission, 312 Rosa Parks Avenue, 23rd Floor, William R. Snodgrass Tennessee Tower, Nashville, TN 37243.