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 return completed form to Benefits Administration. **See page 2 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 ❑ Update Personal Info	❑ New Retiree ❑ Surviving Dependent Continuing Coverage	❑ Retiree ❑ Spouse ❑ Child(ren)	❑ Health ❑ Dental ❑ Vision ❑ The Tenn Plan	ORIGINAL HIRE DATE DATE OF RETIREMENT	TERMINATION DATE

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
❑ MetLife DPPO	❑ retiree ❑ retiree + child(ren)
❑ Cigna DHMO	❑ retiree +spouse ❑ retiree +spouse + child(ren)

PART 6: VISION COVERAGE

PLAN	CHECK DESIRED COVERAGE LEVEL
❑ Basic	❑ retiree ❑ retiree + child(ren)
❑ Expanded	❑ retiree +spouse ❑ retiree +spouse + child(ren)

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 (review document here). ❑ 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, I may be eligible for changes in enrollment of plan members and dependents. 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. I understand that if my dependent loses eligibility, it is my responsibility to notify Benefits Administration, and coverage will terminate at the end of the month in which the loss of eligibility occurs. I understand that I will be held responsible for any claims paid in error.

SIGNATURE	DATE	HOME PHONE	EMAIL ADDRESS AFTER RETIREMENT

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

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.

State and local education 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 as referenced in Section 4 of the State and Local Education Plan Documents. 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 five 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: Eligibility requirements for The Tennessee Plan, supplemental medical insurance for retirees with Medicare, can be found in the Plan Document for The Tennessee Plan at https://www.tn.gov/content/dam/tn/partnersforhealth/documents/medicare_supplement_pd.pdf. You and any 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 Tennessee 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 Tennessee Plan will not pay or coordinate benefits if you are enrolled in a Medicare HMO or Medicare Advantage plan. The Tennessee 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 Tennessee Plan late applicant information.

PART 5 DENTAL: Eligibility requirements for dental coverage can be found in the dental certificates of coverage. The certificates can be viewed at https://www.tn.gov/partnersforhealth/publications/publications.html under the dental drop down menus. 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: You must meet all eligibility requirements found in the vision certificates of coverage. The certificates can be viewed at https://www.tn.gov/partnersforhealth/publications/publications.html under the vision drop down menus.

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 here.

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.