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

- ☐ Enroll in 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: INDICATE YOUR RETIREMENT TYPE

- ☐ I receive a monthly retirement allowance 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

PART 6: ACKNOWLEDGMENTS AND 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 any of my dependents lose eligibility, I know that I must notify Benefits Administration. If I do not, then I will have to pay the plan back for all of my dependent's healthcare bills paid in error. I understand I must submit a copy of my Medicare card for myself and any dependents. I have read and understand the information on page 3, and I have been given an opportunity to ask questions.

SIGNATURE	DATE	HOME PHONE	EMAIL ADDRESS

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 claims administrator 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 Benefits Administration. I understand that all claims paid for ineligible dependents must be repaid to the plan by me.

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 of 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 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 or Higher Education ORP retirement allowance 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. To apply as a late applicant you must complete the applicable sections of pages 1 and 2 and submit your application to Benefits Administration. BA will forward late applications to the TN Plan (Supplemental Medical Insurance for Retirees with Medicare) claims administrator for review. You will be notified directly by the claims administrator 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 RETIREMENT TYPE: This section must be completed to indicate your appropriate retirement type.

PART 6 RETIREE AUTHORIZATION: This section must be signed and dated by the retiree (or surviving dependent if the new head of contract due to retiree death) to confirm all information is accurate. If you have a designated Power of Attorney, a copy of the POA must be attached to this application.

MORE INFORMATION: The Plan Document for The Tennessee Plan is the governing document for this plan. The plan document can be viewed at https://www.tn.gov/partnersforhealth/publications/publications.html.

Language/Communication Assistance. Need free language help? Have a disability and need free help or an auxiliary aid or service, for instance Braille or large print? Please request assistance by emailing benefits.assistance@tn.gov and FA.CivilRights@tn.gov or calling 800-253-9981. If you think you have been denied free language or communications assistance, please call 615-532-9617 for the F&A Civil Rights Coordinator or follow the F & A complaint procedures in F & A Policy No. 36. Non-Discrimination Policy and Complaint Procedure which is available at the following link: Policy 36 - 10.24.2024 pdf

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

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

Chinese
注意：如果您會說中文，則提供免費的語言協助服務。 請致電 1-866-576-0029（電傳打字機：1-800-848-0298）。

Vietnamese
CHÚ Ý: Nếu bạn nói tiếng Việt, dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn. Gọi 1-866-576-0029 (TTY: 1-800-848-0298).

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

French
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-576-0029 (ATS : 1800-848-0298).

Laotian
ຂໍ້ຄວນລະວັງ: ຖ້າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາຟຣີແມ່ນມີຢ່. ໂທ1-866-576-0029 (TTY: 1-800-848-0298).

Amharic
ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-866-576-0029 (መስማት ለተሳናቸው: 1-800-848-0298.

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

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

Japanese
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

Tagalog
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).

Hindi
ध्यान दें: यदद आप द ंदी बोलते तो आपके दलए मुफ्त में भाषा स ायता सेवाएि उपलब्ध ैं। 1-866-576-0029 (TTY: 1800-848-0298) पर कॉल करें।

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

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