



STATE OF TENNESSEE GROUP INSURANCE PROGRAM

APPLICATION FOR MEDICARE SUPPLEMENT TENNESSEE PLAN (NON-TCRS)

State of Tennessee • Department of Finance and Administration • Benefits Administration

26th Floor, William R. Snodgrass TN Tower • Nashville, Tennessee 37243 • 615.741.3590/1.800.253.9981 • Fax: 615.741.8196

For guaranteed issue of coverage, this form must be returned within 60 days of your initial eligibility. A copy of your Medicare card must be enclosed with this application.

RETIREE INFORMATION
Last Name, First Name, Social Security Number, Edison Employee ID (if known)
Street Address, City, State & Zip Code
Phone Number, Birthdate, Marital Status, Gender
Plan Enrollment, Coverage Requested, Eligible for Medicare Part A, Eligible for Medicare Part B
Medicare #, Receiving social security benefits based on disability?, Date Eligible

SPOUSE INFORMATION (if applying)
Last Name, First Name, MI, Gender, Social Security Number
Birthdate, Date of Marriage, Eligible for Medicare Part A, Eligible for Medicare Part B
Receiving social security benefits based on disability?, Date Eligible

DEPENDENT INFORMATION (if applying)
Last Name, First Name, MI, Gender, Social Security Number
Birthdate, Relationship as of (date), Relationship, Student (19-24), Marital Status
Receiving social security benefits based on disability?, Date Eligible

OTHER INSURANCE INFORMATION
Are you or any member of your family covered by a group health insurance company or the holder of another healthcare coverage?
First Name of Insured, Place of Employment
Relationship to Insured, Insurance Company
ID or Policy Number (if known), Insurance Company Address (if known)

**EMPLOYER CERTIFICATION — New eligible retirees only**

This in no way obligates an employer to pay any portion of a retiree's premium.

Does the agency pay any portion of the premium? <input type="checkbox"/> Y <input type="checkbox"/> N	Type of coverage maintained by employee <input type="checkbox"/> Single <input type="checkbox"/> Family	Date employee was first covered under the agency group health plan
Date employee began employment with agency (for retirement purposes) as verified by employment records	Date coverage will be terminated through employer	Total years of service
Agency Name		Phone Number
Signature of Certifying Officer		Title

The following information must be supplied if you are applying 60 days or more past your first Medicare eligibility date.

**RETIREE INFORMATION**

Yes	No	Do you now have or have you had in the last five years any of the following:	
<input type="checkbox"/>	<input type="checkbox"/>	Heart attack	If yes, when:
<input type="checkbox"/>	<input type="checkbox"/>	Cancer (not skin cancer)	If yes, when:
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	If yes, when:
<input type="checkbox"/>	<input type="checkbox"/>	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:	
<input type="checkbox"/>	<input type="checkbox"/>	Heart attack	If yes, when:
<input type="checkbox"/>	<input type="checkbox"/>	Cancer (not skin cancer)	If yes, when:
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	If yes, when:
<input type="checkbox"/>	<input type="checkbox"/>	Kidney failure	If yes, when:

**DEPENDENT INFORMATION (if applying)**

Yes	No	Do you now have or have you had in the last five years any of the following:	
<input type="checkbox"/>	<input type="checkbox"/>	Heart attack	If yes, when:
<input type="checkbox"/>	<input type="checkbox"/>	Cancer (not skin cancer)	If yes, when:
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	If yes, when:
<input type="checkbox"/>	<input type="checkbox"/>	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 signature (if applying) \_\_\_\_\_ Date \_\_\_\_\_