



STATE OF TENNESSEE GROUP INSURANCE PROGRAM
ENROLLMENT/CHANGE APPLICATION — RETIREE DENTAL
 State of Tennessee • Department of Finance and Administration • Benefits Administration
 26th Floor, 312 Rosa L. Parks Avenue • Nashville, TN 37243

TCRS BENEFIT FROM	
<input type="checkbox"/>	State
<input type="checkbox"/>	Higher Ed (UT/TBR)
<input type="checkbox"/>	Local Education
<input type="checkbox"/>	Local Government

See back for complete instructions.

EmplID _____

Part 1 — Enrollment or Change Request (check all that apply)				
ADD <input type="checkbox"/> Retired Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) PLAN <input type="checkbox"/> Prepaid (Assurant) <input type="checkbox"/> PPO (Delta) Effective Date _____	TYPE OF COVERAGE <input type="checkbox"/> Retiree only <input type="checkbox"/> Retiree + 1 <input type="checkbox"/> Retiree + 2 or more	CHANGE <input type="checkbox"/> Marital Status <input type="checkbox"/> Dental Plan <input type="checkbox"/> Prepaid to PPO <input type="checkbox"/> PPO to Prepaid <input type="checkbox"/> Type of Dental Coverage <input type="checkbox"/> Update Dependent Effective Date _____	TERMINATE <input type="checkbox"/> Coverage: all <input type="checkbox"/> Coverage: spouse <input type="checkbox"/> Coverage: child PLAN <input type="checkbox"/> Prepaid (Assurant) <input type="checkbox"/> PPO (Delta) Coverage Termination Date _____	REASON <input type="checkbox"/> Retiree request <input type="checkbox"/> Divorce <input type="checkbox"/> Child age <input type="checkbox"/> Child married <input type="checkbox"/> Child no longer student <input type="checkbox"/> Child no longer claimed on federal income tax <input type="checkbox"/> Death

Part 2 — Retiree Information					
Last Name		First Name	MI	SSN	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		Department Retired From		
Home Address		City	State	Zip Code	County

Part 3 — Dependent Information (see back for eligibility information, attach a separate sheet if necessary)						
Social Security Number	Name Last, First, MI	Birthdate mm/dd/yy	Relationship	Gender	Acquire date *	Student (age 19-24)
				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N
				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N
				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N
				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N

Proof of a dependent's eligibility must be submitted with this application for all new enrollments
 If your dependents (spouse and children) reside at an address other than yours, please provide this information on an attachment
 * **Acquire Date:** the date of marriage, birth, adoption, custody, guardianship or ability to claim on taxes

Part 4 — Authorization		
I confirm that all of the information provided above is accurate. I understand that knowingly providing false and/or misleading information may subject me to disciplinary and/or legal action and may result in loss of insurance coverage. I understand that if my dependent(s) become ineligible for coverage that I must report the change to Benefits Administration within five working days. I understand that all claims paid for ineligible dependents will be recovered. As the policy holder, I am responsible for claims payments to my ineligible dependents.		
Retiree Signature	Date	Daytime Phone

INSTRUCTIONS

PART 1 ENROLLMENT OR CHANGE REQUEST

- Add: Check all appropriate boxes and include effective date. Effective date must be the first of the month.
- Type of Coverage: Check the appropriate box for the number of individuals you are enrolling in the plan.
- Change: Check desired change and include effective date. Effective date must be the first of the month.
- Terminate/Plan: Check coverage to be cancelled. The effective date of coverage termination is the last day of the month in which the event causing termination occurred.
- Reason: Check the appropriate reason for termination.

PART 2 RETIREE INFORMATION

Complete each line in full.

PART 3 DEPENDENT INFORMATION

If you elect to cover dependents, you must provide all information requested in Part 3 for each dependent. You must provide a social security number for any dependent two years of age or older. If your dependents (spouse and children) reside at an address other than yours, please provide this information on an attachment. Dependent children are eligible for coverage until the end of the month in which they reach age 19. Dependent children age 19 to 24 may only continue coverage if unmarried and either a full-time student or claimed on your federal income tax return.

The following individuals are eligible for dependent coverage through the state group insurance program:

- Legally married spouse
- Natural (biological) child
- Legally adopted child
- Stepchild for whom you or your spouse has legal or joint custody or shared parenting
- Any child living in your home for 12 months per year for whom you are the legal guardian
- Any child living in your home for 12 months per year who you claim on your federal income tax return

IMPORTANT: It is your responsibility to notify Benefits Administration of any changes in the eligibility status of a dependent.

The following are *not eligible* for coverage as your dependent through the state group insurance program:

- Ex-spouse (even if court ordered)
- Parents of the employee or spouse
- Children in the armed forces on a full-time basis
- Children over age 24 (unless they meet qualifications for incapacitation)
- Married children, regardless of age
- Foster children
- Live-in companions not legally married to the employee

Acquire dates are needed solely for the purposes of determining eligibility.

STUDENT: Check yes or no for any unmarried dependent child older than 18 years and 11 months of age. A full-time student is one who is registered for at least the number of credit hours that the institution requires in its definition of full-time student status and who attends classes for two of three semesters or three of four quarters in any 12-month period. Health insurance providers are required to verify student status for dependents over the age of 18 years and 11 months annually. If you fail to return the verification information your dependent is subject to termination.

If your dependents are not currently enrolled in coverage with the state group insurance program, proof of eligibility is required with your enrollment application before they will be enrolled in coverage. Types of acceptable documents include the following:

- Spouse (1) Page 1 **AND** signature page of your prior year federal tax return listing the spouse name and marked either married filing jointly or married filing separately; **OR**
(2) Marriage certificate **and** proof of joint ownership or tenancy
- Child under 19 (1) Page 1 **AND** signature page of your prior year federal tax return; **OR**
(2) Birth certificate
- Child 19 to 24 (1) Proof of attending school full-time such as a letter from the registrar office or a transcript; **OR**
(2) Page 1 **AND** signature page of your prior year federal tax return

Please visit the Benefits Administration web site at www.tn.gov/finance/ins/ to view a complete list of dependent definitions and acceptable documentation.

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 or national origin. If you have a complaint regarding discrimination, please call 1.866.576.0029 or 615.741.4517.