



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



PART 1: ACTION REQUESTED — PLEASE SEE PAGE 4 FOR INSTRUCTIONS

TYPE OF ACTION	REASON FOR ACTION	PARTICIPANTS AFFECTED	COVERAGE AFFECTED	EFFECTIVE DATE REQUESTED	
<input type="checkbox"/> Add Coverage <input type="checkbox"/> Change Coverage <input type="checkbox"/> Terminate Coverage <input type="checkbox"/> Update Personal Info	<input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Special Qualifying Event (also complete page 3)	<input type="checkbox"/> Court Order <input type="checkbox"/> Legal Guardianship <input type="checkbox"/> Newborn/Adoption <input type="checkbox"/> Family Status Change	<input type="checkbox"/> Retiree <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)	<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision	

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: GROUP HEALTH COVERAGE SELECTION

BENEFIT OPTION	CARRIER	REGION WHERE YOU LIVE	HEALTH PREMIUM LEVEL
<input type="checkbox"/> Standard PPO <input type="checkbox"/> Partnership Promise PPO <input type="checkbox"/> No Partnership Promise PPO <input type="checkbox"/> Limited PPO (local ed/local gov only) <input type="checkbox"/> HealthSavings CDHP	<input type="checkbox"/> BlueCross BlueShield (Network S) <input type="checkbox"/> Cigna (LocalPlus) <input type="checkbox"/> Cigna Open Access (surcharge applies)	<input type="checkbox"/> East <input type="checkbox"/> Middle <input type="checkbox"/> West <small>See page 4 for map and information for out of state residents</small>	<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	CHECK ALL THAT APPLY	PLAN	CHECK ALL THAT APPLY (must be enrolled in group health)
<input type="checkbox"/> DPPO <input type="checkbox"/> Prepaid DHMO	<input type="checkbox"/> retiree <input type="checkbox"/> spouse <input type="checkbox"/> child(ren)	<input type="checkbox"/> Basic <input type="checkbox"/> Expanded	<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	DATE EFFECTIVE
			<input type="checkbox"/> M <input type="checkbox"/> F		PART A <input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> M <input type="checkbox"/> F		PART A <input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> M <input type="checkbox"/> F		PART A <input type="checkbox"/> Y <input type="checkbox"/> N	

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 all of the information above is true. If coverage is being continued in the Partnership PPO, or if I am enrolling via special qualifying event and I choose the Partnership PPO, then I agree to the terms and conditions of the Partnership Promise for the plan year indicated on page 4. I know that I can lose my insurance if I give false information. I may also face disciplinary and legal charges. If my dependents lose eligibility, I know that I must tell Benefits Administration within one calendar month. If I do not, then I will have to pay the plan back for all of my dependent's healthcare bills. I authorize healthcare providers to give my insurance carrier the medical and insurance records for me and my dependents.

SIGNATURE	DATE	HOME PHONE
EMAIL ADDRESS	AGENCY RETIRED FROM	

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

Dependent Eligibility Definitions and Required Documents

TYPE OF DEPENDENT	DEFINITION	REQUIRED DOCUMENT(S) FOR VERIFICATION
Spouse	A person to whom the participant is legally married	<p>You will need to provide a document proving marital relationship AND a document proving joint ownership</p> <p>Proof of Marital Relationship</p> <ul style="list-style-type: none"> • Government issued marriage certificate or license • Naturalization papers indicating marital status <p>Proof of Joint Ownership</p> <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” (if married filing separately, submit page 1 of both returns) or form 8879 (electronic filing) <p>If just married in the previous 12 months, only a marriage certificate is needed for proof of eligibility</p>
Natural (biological) child under age 26	A natural (biological) child	<p>The child’s birth certificate; or</p> <p>Certificate of Report of Birth (DS-1350); or</p> <p>Consular Report of Birth Abroad of a Citizen of the United States of America (FS-240); or</p> <p>Certification of Birth Abroad (FS-545)</p>
Adopted child under age 26	A child the participant has adopted or is in the process of legally adopting	<p>Court documents signed by a judge showing that the participant has adopted the child; or</p> <p>International adoption papers from country of adoption; or</p> <p>Papers from the adoption agency showing intent to adopt</p>
Child for whom the participant is legal guardian	A child for whom the participant is the legal guardian	Any legal document that establishes guardianship
Stepchild under age 26	A stepchild	<p>Verification of marriage between employee and spouse (as outlined above) and birth certificate of the child showing the relationship to the spouse; or</p> <p>Any legal document that establishes relationship between the stepchild and the spouse or the member</p>
Child for whom the plan has received a qualified medical child support order	A child who is named as an alternate recipient with respect to the participant under a qualified medical child support order (QMCSO)	<p>Court documents signed by a judge; or</p> <p>Medical support orders issued by a state agency</p>
Disabled dependent	A dependent of any age (who falls under one of the 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.	Documentation will be provided by the insurance carrier at the time incapacitation is determined

Revised 1/2016

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
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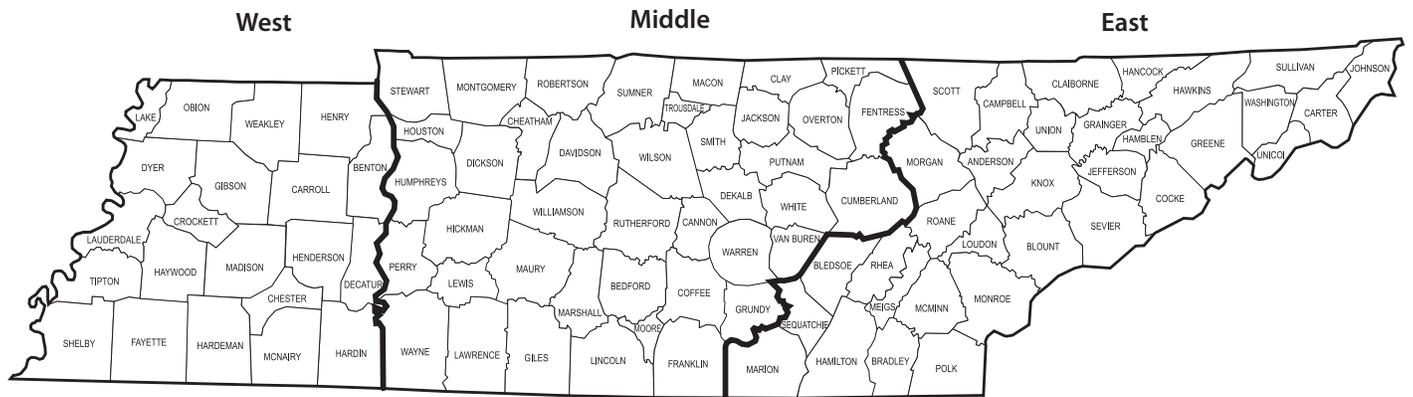
Special Enrollment Qualifying Events

The federal law, Health Insurance Portability Accountability Act (HIPAA), allows you and your dependents to enroll in health coverage under certain conditions. Exceptions will also be made for you or your dependents if you lose health coverage offered through your spouse's or ex-spouse's employer. You or your dependents may also be eligible to enroll in dental and vision coverage when lost with another employer. If you are adding dependents to your existing coverage, you and your dependents may transfer to a different carrier or healthcare option, if eligible. Premiums are not prorated. If approved, you must pay premium for the entire month in which the effective date occurs.

Identify the qualifying event(s) which caused the loss of other coverage for you and/or your eligible dependent(s). You must submit this page with the appropriate required documentation, proof of prior coverage and a completed enrollment application. Application for enrollment must be made within 60 days of the loss of insurance coverage or within 60 days of a new dependent's acquire date.

QUALIFYING EVENT	DOCUMENTATION REQUIRED	EFFECTIVE DATE
<input type="checkbox"/> Death of spouse or ex-spouse	Copy of death certification and written documentation from the employer on company letterhead providing names of covered participants and date coverage ended	Day after loss of coverage OR first day of the month following loss of other coverage
<input type="checkbox"/> Divorce	Copy of the signed divorce decree and written documentation from the employer on company letterhead providing names of covered participants, date coverage ended and what coverage was lost (i.e., medical, dental, vision)	Day after loss of coverage OR first day of the month following loss of other coverage
<input type="checkbox"/> Legal separation	Copy of the agreed order of legal separation and written documentation from the employer on company letterhead providing names of covered participants, date coverage ended, reason why coverage ended and what coverage was lost (i.e., medical, dental, vision)	Day after loss of coverage OR first day of the month following loss of other coverage
<input type="checkbox"/> Loss of eligibility (does not include a loss due to failure to pay premiums or termination of coverage for cause)	Written documentation from the employer or the insurance company on company letterhead providing the names of covered participants, date coverage ended, reason for the loss of eligibility and what coverage was lost (i.e., medical, dental, vision)	Day after loss of coverage OR first day of the month following loss of other coverage
<input type="checkbox"/> Loss of coverage due to exhausting lifetime benefit maximum	Written documentation from the insurance company on company letterhead providing the names of covered participants, date coverage ended, stating that the lifetime maximum has been met and what coverage was lost (i.e., medical, dental, vision)	Day after loss of coverage OR first day of the month following loss of other coverage
<input type="checkbox"/> Loss of TennCare (does not include a loss due to failure to pay premiums)	Written documentation from TennCare providing the names of covered participants, date coverage ended and the reason why coverage ended	Day after loss of coverage OR first day of the month following loss of other coverage
<input type="checkbox"/> Termination of spouse's or ex-spouse's employment (voluntary and non-voluntary)	Written documentation from the employer on company letterhead providing names of covered participants, date coverage ended, reason why coverage ended and what coverage was lost (i.e., medical, dental, vision)	Day after loss of coverage OR first day of the month following loss of other coverage
<input type="checkbox"/> Employer eliminated contribution to spouse's, ex-spouse's or dependent's insurance coverage (total contribution, not partial)	Written documentation from the employer on company letterhead providing names of covered participants, date contribution amount changed, date coverage ended and what coverage was lost (i.e., medical, dental, vision)	Day after loss of coverage OR first day of the month following loss of other coverage
<input type="checkbox"/> Spouse's or ex-spouse's work hours reduced causing loss of eligibility for insurance coverage	Written documentation from the employer on company letterhead providing names of covered participants, date coverage ended, reason why coverage ended and what coverage was lost (i.e., medical, dental, vision)	Day after loss of coverage OR first day of the month following loss of other coverage
When a new dependent is acquired, a non-covered employee may use the event to enroll in employee only or family coverage. If the employee is already enrolled, they may add the new dependent and previously eligible dependents (those who were not enrolled when initially eligible and are otherwise still eligible). Required documentation is listed below. Employees only requesting to add a new dependent should follow regular enrollment procedures.		
<input type="checkbox"/> Acquires a new dependent — spouse	Copy of marriage certificate	Date of marriage OR first day of the month following marriage
<input type="checkbox"/> Acquires a new dependent — newborn	Copy of birth certificate for newborn	Date of birth
<input type="checkbox"/> Acquires a new dependent — adoption/ legal custody	Copy of adoption documents	Date of adoption or legal custody

Counties and Regions For Health Plans



Out of state residents: If you do not live in Tennessee, you will be eligible to enroll in the middle region options.

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, change or terminate 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.

2017 PARTNERSHIP PROMISE

Members and covered spouses must:

- Complete the online Healthways Well-Being Assessment® (health questionnaire) between January 1 and March 15, 2017
- Complete a biometric health screening by July 15, 2017
- Actively participate in coaching, if you are called
 - » Coaching includes disease management [diabetes, chronic obstructive pulmonary disease (COPD), asthma, heart failure and congestive heart disease (CHD)] and/or case management administered by BlueCross BlueShield, Cigna and Optum
- Keep your contact information current with Benefits Administration, or if a covered spouse, with Healthways

Newly covered members:

New plan members are required to complete the online Well-Being Assessment and biometric screening within 120 days of their insurance coverage effective date. Children enrolled in the health plan are not required to complete the Partnership Promise. Visit our website at partnersforhealthtn.gov for more information about the Partnership Promise.

A person who knowingly provides false information to maintain benefits may have to pay a higher premium to stay in the Partnership Promise PPO. In addition, the state insurance plans have the right to recover the cost of benefits from any member who has received these benefits through false information.

Enrollment in the Partnership Promise PPO. By choosing a plan that requires the Partnership Promise, you and your dependent spouse (if applicable), have the opportunity to qualify for a premium discount by completing the Partnership Promise requirements each year that you are enrolled. If you do not fulfill the requirements, you will not get the premium discount in the Partnership Promise PPO. During the annual enrollment period each year, you may select another health insurance option. If you do not do so, you will continue to be enrolled in your current plan, if eligible.

Requirements of the Partnership Promise PPO. You will be informed of the requirements of the Partnership Promise on or before the annual enrollment period each year. The benefits of the Partnership Promise are open to all plan members. If you think you might be unable to fulfill the Partnership Promise, call our Partners for Health Wellness Program at 888.741.3390. They will work with you and/or your physician, if you wish, to find an alternate way for you to meet the Promise.

Non-Completion of Partnership Promise requirements. Members who do not complete the requirements of the Partnership Promise will be sent written notification and will have the opportunity to respond to the notice.