RESET

STATE OF TENNESSEE GROUP INSURANCE PROGRAM

ENROLLMENT 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

PARTNERS FOR HEALTH

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

TYPE OF ACTION
- ❑ Add coverage
- ❑ Change coverage
- ❑ Terminate coverage

COVERAGE
- ❑ Health
- ❑ Dental
- ❑ Vision
- ❑ Disability

PARTICIPANTS AFFECTED
- ❑ Employee
- ❑ Spouse
- ❑ Child(ren)

REASON FOR THIS ACTION
- ❑ New Hire/Newly Eligible
- ❑ Termination
- ❑ Court Order
- ❑ Other _____

Life Event
- ❑ Marriage
- ❑ Newborn
- ❑ Legal Guardianship
- ❑ Adoption

Special Enrollment (also complete pg 3)
- ❑ Death
- ❑ Divorce
- ❑ Loss of Eligibility

PART 2: EMPLOYEE INFORMATION

FIRST NAME	MI	LAST NAME	DATE OF BIRTH	GENDER ❑ M ❑ F	MARITAL STATUS ❑ S ❑ M ❑ D ❑ W

SOCIAL SECURITY NUMBER	EMPLOYING AGENCY	EMPLOYER GROUP: ❑ UT ❑ TBR ❑ State ❑ Local Ed ❑ Local Gov	YOUR CURRENT STATUS ❑ Active ❑ COBRA

HOME ADDRESS ❑ UPDATE MY ADDRESS	CITY	ST	ZIP CODE	COUNTY

PART 3: HEALTH COVERAGE SELECTION

SELECT AN OPTION
- ❑ Premier PPO
- ❑ CDHP/HSA (state)
- ❑ Standard PPO

LOCAL ED & GOV ONLY MAY ALSO CHOOSE
- ❑ Limited PPO
- ❑ Local CDHP/HSA

EMPLOYEE HSA CONTRIBUTION (STATE ONLY)

Annual contribution

$_____

SELECT A CARRIER
- ❑ BlueCross BlueShield Network S
- ❑ Cigna LocalPlus
- ❑ Cigna Open Access (surcharge applies)

REGION WHERE YOU LIVE OR WORK
- ❑ East
- ❑ Middle
- ❑ West

SELECT A HEALTH PREMIUM LEVEL
- ❑ employee only
- ❑ employee + child(ren)
- ❑ employee + spouse
- ❑ employee + spouse + child(ren)

PART 4: DENTAL COVERAGE SELECTION

SELECT A PLAN
- ❑ MetLife DPPO
- ❑ Cigna Prepaid DHMO

SELECT A DENTAL PREMIUM LEVEL
- ❑ employee only
- ❑ employee + child(ren)
- ❑ employee + spouse
- ❑ employee + spouse + child(ren)

PART 5: VISION COVERAGE SELECTION

SELECT A PLAN
- ❑ Basic Plan
- ❑ Expanded Plan

SELECT A VISION PREMIUM LEVEL
- ❑ employee only
- ❑ employee + child(ren)
- ❑ employee + spouse
- ❑ employee + spouse + child(ren)

PART 6: DISABILITY SELECTION (ST/UT/TBR)

SHORT TERM DISABILITY
- ❑ 14/14 Elimination Period
- ❑ 30/30 Elimination Period

LONG TERM DISABILITY (ST ONLY)
- ❑ 60%/90 day Elim Period
- ❑ 60%/180 day Elim Period
- ❑ 63%/90 day Elim Period
- ❑ 63%/180 day Elim Period

PART 7: DEPENDENT INFORMATION — ATTACH A SEPARATE SHEET IF NECESSARY

NAME (FIRST, MI, LAST)	DATE OF BIRTH	RELATIONSHIP	GENDER	ACQUIRE DATE *	SOCIAL SECURITY NUMBER	HEALTH	DENTAL	VISION
			❑ M ❑ F			❑	❑	❑
			❑ M ❑ F			❑	❑	❑
			❑ M ❑ F			❑	❑	❑

* The acquire date is the date of marriage, birth, adoption or guardianship.
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 8: EMPLOYEE AUTHORIZATION

❑ Accept — 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. I understand that if my dependent loses eligibility, coverage will terminate at the end of the month in which the loss of eligibility occurs. I further understand that it is my responsibility to notify my benefits coordinator of the loss of eligibility and I will be held responsible for any claims paid in error for any reason. I authorize my employer to take deductions from my paycheck to pay for my benefit costs. Finally, I authorize healthcare providers to give my insurance carrier the medical and insurance records for me and my dependents.

❑ Refuse — I have been given the opportunity by my employer to apply for the group insurance program and have decided not to take advantage of this offer. I understand that if I later wish to apply, I or my dependents will have to provide proof of a special qualifying event or wait until annual enrollment.

EMPLOYEE SIGNATURE	DATE	HOME PHONE (REQUIRED)	EMAIL ADDRESS (REQUIRED)

AGENCY SECTION — RETURN THIS FORM TO YOUR AGENCY BENEFITS COORDINATOR

ORIGINAL HIRE DATE	COVERAGE BEGIN/END DATE	POSITION NUMBER	EDISON ID	NOTES TO BENEFITS ADMINISTRATION

AGENCY BENEFITS COORDINATOR SIGNATURE	DATE	❑ PPACA Eligible ❑ 1450 Eligible

Active employees should return this completed form to your agency benefits coordinator. COBRA participants should send 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	You will need to provide a document proving marital relationship **AND** a document proving joint ownership
		Proof of Marital Relationship • Government issued marriage certificate or license • Naturalization papers indicating marital status
		Proof of Joint Ownership • 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)
		If just married in the previous 12 months, only a marriage certificate is needed for proof of eligibility
Natural (biological) child under age 26	A natural (biological) child	The child's birth certificate; **or**
		Certificate of Report of Birth (DS-1350); **or**
		Consular Report of Birth Abroad of a Citizen of the United States of America (FS-240); **or**
		Certification of Birth Abroad (FS-545)
Adopted child under age 26	A child the participant has adopted or is in the process of legally adopting	Court documents signed by a judge showing that the participant has adopted the child; **or**
		International adoption papers from country of adoption; **or**
		Papers from the adoption agency showing intent to adopt
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	Verification of marriage between employee and spouse (as outlined above) and birth certificate of the child showing the relationship to the spouse; **or**
		Any legal document that establishes relationship between the stepchild and the spouse or the member
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)	Court documents signed by a judge; **or**
		Medical support orders issued by a state agency
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

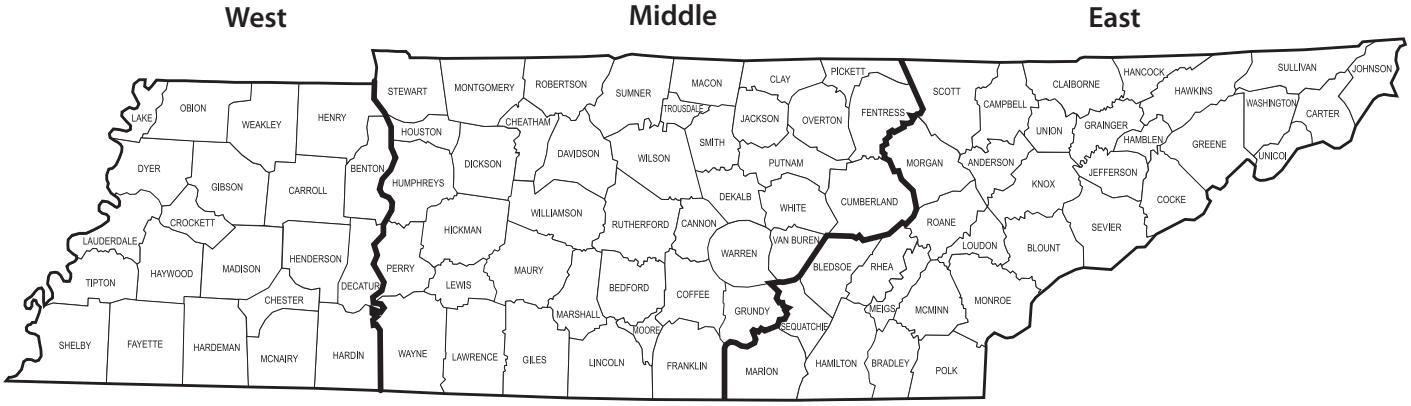
Special Enrollment Qualifying Events

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
❑ 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
❑ 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
❑ 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
❑ 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
❑ 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
❑ 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
❑ 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
❑ 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
❑ 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.		
❑ Acquires a new dependent — spouse	Copy of marriage certificate	Date of marriage **OR** first day of the month following marriage
❑ Acquires a new dependent — newborn	Copy of birth certificate for newborn	Date of birth
❑ Acquires a new dependent — adoption/ legal custody	Copy of adoption documents	Date of adoption or legal custody

Counties and Regions For Health Plans



Active employees can select the region where they either live or work. COBRA participants must select the region where they live.

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.

To add, change or terminate health, dental or vision coverage during the annual enrollment period, follow these instructions for each section in Part 1:

TYPE OF ACTION — mark the box indicating that you want to add, change or terminate coverage

COVERAGE AFFECTED — mark all that apply

PARTICIPANTS AFFECTED — mark all that apply

REASON FOR THIS ACTION — indicate reason for action – if making changes during annual enrollment period mark "Other" and write in AEP

Please make sure the rest of the form is filled out completely and be sure to sign and date the form. If you are an active employee, return your completed form to your agency benefits coordinator.

Anti-Discrimination and Civil Rights Compliance

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, national origin, sex, age or disability in its health programs and activities. If you have a complaint regarding discrimination, please call 1-866-576-0029.

If you think you have been treated in a different way for these reasons, please mail this information to Benefits Administration:

- Your name, address and phone number. You must sign your name. (If you write for someone else, include your name, address, phone number and how you are related to that person, for instance wife, lawyer or friend.)
- The name and address of the program you think treated you in a different way.
- How, why and when you think you were treated in a different way.
- Any other key details.

Mail to: State of Tennessee, Benefits Administration, Civil Rights Compliance, Department of Finance and Administration, 19th Floor, 312 Rosa L. Parks Avenue, William R. Snodgrass Tennessee Tower, Nashville, TN 37243-1102

Need free language help? Have a disability and need free help or an auxiliary aid or service, for instance Braille or large print? Please call 1-866-576-0029.

You may also contact the: U.S. Department of Health & Human Services – Region IV Office for Civil Rights, Sam Nunn Atlanta Federal Center, Suite 16T70, 61 Forsyth Street, SW, Atlanta, Georgia 30303-8909 or 1-800-368-1019 or TTY/TDD at 1-800-537-7697

If you speak a language other than English, help in your language is available for free. This tells you how to get help in a language other than English.

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

1 برقم اتصل يا المجان لك تتوافر الـ لغويـة الـ مساعدة خدمات فإن الـ لغة، اذكر تتحدث كنت إذا: ملحوظة -576-0029 (رقم 866-
1: والـ بكم الصم هاتف -800-848-0298).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-576-0029 (TTY:1-800-848-0298) 。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-576-0029 (TTY:1-800-848-0298).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-576-0029 (TTY: 1-800-848-0298) 번으로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-576-0029 (ATS : 1-800-848-0298).

Ni songen mwohmw ohte, komw pahn sohte anahne kawehwe mesen nting me koatoantoal kan ahpw wasa me ntingie [Lokaiahn Pohnpei] komw kalangan oh ntingidieng ni lokaiahn Pohnpei. Call 1-866-576-0029 (TTY: 1-800-848-0298).

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

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

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

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。

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).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-866-576-0029 (TTY: 1-800-848-0298) पर कॉल करें।

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

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