RESET

STATE OF TENNESSEE GROUP INSURANCE PROGRAM

ANNUAL ENROLLMENT TRANSFER — DENTAL APPLICATION

State of Tennessee • Department of Finance and Administration • Benefits Administration
312 Rosa L. Parks Avenue • Suite 2600 • Nashville, TN 37243 • Fax: 615.741.8196

PARTNERS FOR HEALTH

PART 1: ACTION REQUESTED

PARTICIPANT STATUS	ADD	CHANGE	TERMINATE
❑ Active Employee	❑ Coverage: Self	❑ Transfer to Delta PDO	❑ Coverage: Self
❑ COBRA	❑ Coverage: Spouse	❑ Transfer to Assurant Prepaid	❑ Coverage: Spouse
❑ Retiree	❑ Coverage: Child(ren)		❑ Coverage: Child(ren)

PART 2: APPLICANT INFORMATION

LAST NAME	FIRST NAME	MI	SSN OR EDISON ID

DATE OF BIRTH	GENDER	MARITAL STATUS	EMPLOYER/RETIREE GROUP: ❑ UT ❑ TBR	EFFECTIVE DATE
	❑ M ❑ F		❑ STATE ❑ LOCAL ED ❑ LOCAL GOV	

HOME ADDRESS	CITY	ST	ZIP CODE	COUNTY

PART 3: DENTAL COVERAGE SELECTION

SELECT A PLAN

❑ Delta Preferred Dental Organization

❑ Assurant Prepaid Plan — You MUST select a Tennessee dentist from the list of participating network dentists

SELECT A DENTAL PREMIUM LEVEL

❑ employee only ❑ employee + spouse

❑ employee + child(ren) ❑ employee + spouse + child(ren)

PART 4: DEPENDENT INFORMATION — LIST ALL DEPENDENTS YOU WISH TO COVER (ATTACH A SEPARATE SHEET IF NECESSARY)

SOCIAL SECURITY NUMBER	NAME (LAST, FIRST, MI)	BIRTHDATE	GENDER	RELATIONSHIP	ACQUIRE DATE *
			❑ M ❑ F		
			❑ 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.

❑ A separate sheet with more dependents is attached

PART 5: 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 my dependents lose eligibility, I know that I must tell Benefits Administration within five working days. If I do not, then I will have to pay the plan back for all of my dependent's health care bills. Finally, I authorize healthcare providers to give my insurance carrier the medical and insurance records for me and my dependents.

SIGNATURE	DATE	HOME PHONE

Application must be received by November 1, 2011. Any enrollment changes will be effective January 1, 2012.

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	Page 1 and signed and dated signature page of participant's prior year Federal Income Tax Return (1040, 1040A or 1040EZ) listing the spouse name and marked either married filing jointly or married filing separately; **or**
		Page 1 and Certificate of Electronic Filing (must show as accepted) of participant's prior year Federal Income Tax Return (1040, 1040A or 1040EZ) listing the spouse name and marked either married filing jointly or married filing separately; **or**
		Marriage certificate and one of the following: • Proof that participant and spouse own a home or other real estate together • Proof that participant and spouse are both listed on a lease or share the rent of a home or other property • A utility bill with both names • Proof of a jointly-owned bank or financial account • Proof of a joint loan or debt obligation
		If just married in the current calendar year, a marriage certificate only is acceptable 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 quardian	Any legal document that establishes guardianship
Stepchild under age 26	A stepchild	Verification of marriage between employee and spouse 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

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.