



STATE OF TENNESSEE GROUP INSURANCE PROGRAM  
**HEALTH / DENTAL ENROLLMENT CHANGE 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**  
 EMPLOYEE OR COBRA

**Part 1: Action Requested — please see page 4 for instructions**

<b>Type of Action</b> <input type="checkbox"/> Add Coverage <input type="checkbox"/> Change Coverage <input type="checkbox"/> Terminate Coverage <input type="checkbox"/> Update Personal Info	<b>Coverage Affected</b> <input type="checkbox"/> Health <input type="checkbox"/> Dental	<b>Participants Affected</b> <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)	<b>Reason for This Action</b> <input type="checkbox"/> New Hire/Newly Eligible <input type="checkbox"/> Terminate Employment <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"/> Other (specify) _____	<input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Death
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**Part 2: Employee 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	Employing Agency		Employer Group: <input type="checkbox"/> UT <input type="checkbox"/> TBR <input type="checkbox"/> State <input type="checkbox"/> Local Ed <input type="checkbox"/> Local Gov		Your Current Status <input type="checkbox"/> Active <input type="checkbox"/> COBRA
Home Address	<input type="checkbox"/> Update my address	City	ST	ZIP Code	County

**Part 3: Health Coverage Selection**

<b>Select a Benefit Option</b> <input type="checkbox"/> Standard PPO <input type="checkbox"/> Partnership PPO <input type="checkbox"/> Limited PPO (available to local government only)	<b>Select a Carrier</b> <input type="checkbox"/> BlueCross BlueShield Network S <input type="checkbox"/> CIGNA Open Access Plus	<b>Select Region Where You Live or Work</b> <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>	<b>Select a Health Premium Level</b> <input type="checkbox"/> employee only <input type="checkbox"/> employee + spouse + child(ren) <input type="checkbox"/> employee + spouse <input type="checkbox"/> employee + child(ren)
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**Part 4: Dental Coverage Selection**

<b>Select a Plan</b> <input type="checkbox"/> Delta Preferred Dental Organization <input type="checkbox"/> Assurant Prepaid Plan	<small>Check with your agency to see if you are eligible for dental coverage</small>	<b>Select a Dental Premium Level</b> <input type="checkbox"/> employee only <input type="checkbox"/> employee + spouse + child(ren) <input type="checkbox"/> employee + spouse <input type="checkbox"/> employee + child(ren)
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**Part 5: Dependent Information — attach a separate sheet if necessary**

Name (First, MI, Last)	Date of Birth	Relationship	Gender	Acquire date *	Social Security Number	Health	Dental
			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/>	<input type="checkbox"/>

\* 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 6: Employee Authorization**

**Accept** I confirm that all of the information above is true. If I chose 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 my benefits coordinator 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. I authorize my employer to take deductions from my paycheck to pay for my benefits 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.

Employee Signature	Date	Home Phone	Email Address
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**Agency Section — Return this Form to your Agency Benefits Coordinator**

Original Hire Date	Coverage Begin/End Date	Position Number	Edison ID	(Optional) Notes to Benefits Administration
Agency Benefits Coordinator Signature			Date	

## 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; <b>or</b>
		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; <b>or</b>
		Marriage certificate and one of the following: <ul style="list-style-type: none"> <li>• Proof that participant and spouse own a home or other real estate together</li> <li>• Proof that participant and spouse are both listed on a lease or share the rent of a home or other property</li> <li>• A utility bill with both names</li> <li>• Proof of a jointly-owned bank or financial account</li> <li>• Proof of a joint loan or debt obligation</li> </ul>
		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; <b>or</b>
		Certificate of Report of Birth (DS-1350); <b>or</b>
		Consular Report of Birth Abroad of a Citizen of the United States of America (FS-240); <b>or</b>
		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; <b>or</b>
		International adoption papers from country of adoption; <b>or</b>
		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 and birth certificate of the child showing the relationship to the spouse; <b>or</b>
		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; <b>or</b>
		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.**

Employee Name	Edison ID	<b>OR</b>	SSN
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## Special Enrollment Qualifying Events

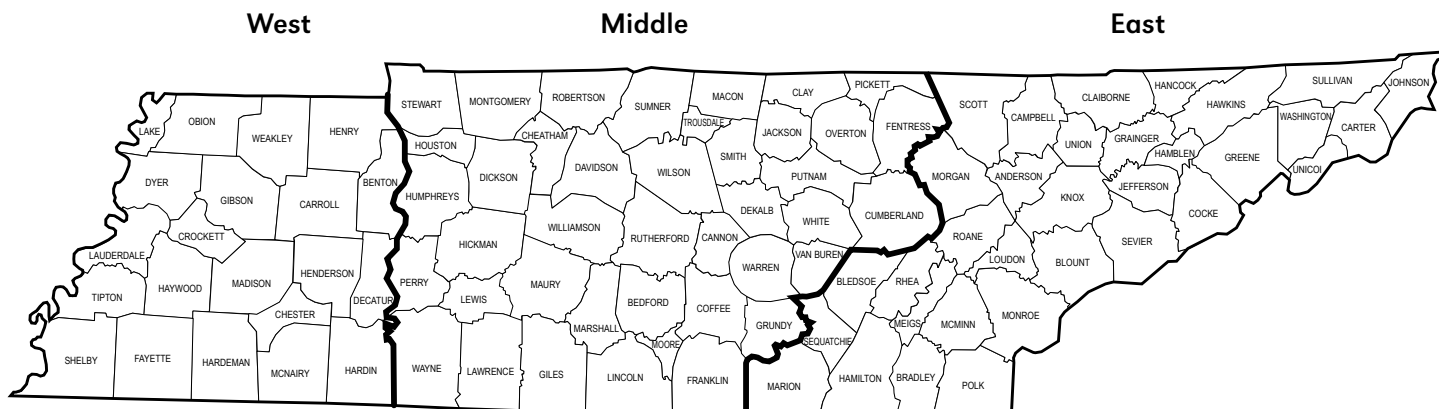
The federal law, Health Insurance Portability Accountability Act (HIPAA) allows employees and dependents to enroll in health coverage under certain conditions. Exceptions will also be made for eligible employees or dependents if they lose their health coverage offered through the employer of the employee's spouse/ex-spouse.

Identify the qualifying event which caused the loss of other medical coverage for you and your eligible dependents. You must submit this page with the appropriate required documentation, proof of prior coverage and a completed group insurance program enrollment change application. Application for enrollment must be submitted within 60 days of the loss of insurance coverage.

QUALIFYING EVENT	DOCUMENTATION REQUIRED
<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 ends.
<input type="checkbox"/> Divorce	Copy of the signed divorce decree and written documentation from the employer on company letterhead providing names of covered participants and date coverage ends.
<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 ends, and the reason why coverage ended.
<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 ends and the reason for the loss of eligibility.
<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 and stating that the lifetime maximum has been met.
<input type="checkbox"/> Loss of TennCare (does not include a loss due to failure to pay premiums)	Written documentation from TennCare on company letterhead stating that coverage has been or will be terminated.
<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 ends and reason why coverage ended.
<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 and date coverage ended.
<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 ends and reason why coverage ended.
Employees who are acquiring a new dependent may also <b>add other previously eligible dependents</b> to coverage at the same time. This is considered a qualifying event and the documentation listed below will also be required.	
<input type="checkbox"/> Acquires a new dependent – spouse ( <b>and</b> adding other previously eligible dependents)	Copy of marriage certificate.
<input type="checkbox"/> Acquires a new dependent – newborn ( <b>and</b> adding other previously eligible dependents)	Copy of birth certificate for newborn.
<input type="checkbox"/> Acquires a new dependent – adoption/legal custody ( <b>and</b> adding other previously eligible dependents)	Copy of adoption documents.

The effective date of coverage for a participant approved through a special enrollment provision is either (1) the first of the month in which other coverage was lost, if other coverage was lost in the middle of the month; (2) the first of the month following loss of other coverage if other coverage was lost at the end of the month; (3) the first of the month following the 60-day period of the loss of insurance coverage; (4) the first of the month or first of the subsequent month following approval by the committee or its representative (only if administrative review is required); (5) the day on which the event occurred, if enrollment is waived due to birth, adoption or placement for adoption; (6) the day on which the event occurred or the first day of the subsequent month, if enrollment is waived due to marriage. If you are currently enrolled in health coverage and have a dependent approved for coverage through a special enrollment qualifying event, you and your covered dependents may transfer to another healthcare option.

## 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 a state that borders Tennessee, select the middle region. If you live in a bordering state, select the region closest to the border.

### 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 or dental coverage during the Annual Enrollment Transfer Period (AETP) from October 1 – November 1, 2011, 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 or update personal information.

COVERAGE AFFECTED – mark health, dental or both.

PARTICIPANTS AFFECTED – mark all that apply.

REASON FOR THIS ACTION – mark “Other” and write in AETP.

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.

### 2012 PARTNERSHIP PROMISE

Member Requirements:

1. Members (and spouses covered by their insurance) must participate in health coaching if an opportunity to improve your health is identified by ParTNers for Health Wellness staff during 2012.
2. Members must keep their address, phone number and email, if they have one, current with their employer.

Note - If it is unreasonably difficult because of a medical or mental health condition for you to achieve the standards to fulfill the Partnership Promise, or if it is medically inadvisable for you to attempt to fulfill the Partnership Promise, call us at 1-888-741-3390, and we will work with you to develop another way to qualify for the Partnership PPO.

**Enrollment in Partnership PPO.** By choosing the Partnership PPO you, and your dependent spouse (if applicable), agree to complete the Partnership Promise requirements each year that you are enrolled in the Partnership PPO. During the Annual Enrollment Transfer Period (AETP) each year, you may select another health insurance option. If you do not do so, you will continue to be enrolled in the Partnership PPO, if eligible.

**Requirements of the Partnership PPO.** You will be informed of the requirements of the Partnership Promise on or before AETP each year. Beginning in 2012, the requirements must be completed by the end of each year in which you are a member of the Partnership PPO. If you are unable to complete the requirements of the Partnership Promise because of a medical or mental health condition we will work with you to develop an alternative way to qualify for the Partnership PPO.

**Disenrollment from Partnership PPO.** If you, or your dependent spouse, do not complete the requirements of the Partnership Promise you and all of your covered dependents will be unable to enroll in the Partnership PPO for one year. 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.