RESET

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

Type of Action
- ❑ Add Coverage
- ❑ Change Coverage
- ❑ Terminate Coverage
- ❑ Update Personal Info

Coverage Affected
- ❑ Health
- ❑ Dental

Participants Affected
- ❑ Employee
- ❑ Spouse
- ❑ Child(ren)

Reason for This Action
- ❑ New Hire/Newly Eligible
- ❑ Terminate Employment
- ❑ Special Qualifying Event (also complete page 3)
- ❑ Court Order
- ❑ Legal Guardianship
- ❑ Newborn/Adoption
- ❑ Other (specify) _____
- ❑ Marriage
- ❑ Divorce
- ❑ Death

Part 2: Employee Information

First Name	MI	Last Name	Date of Birth	Gender	Marital Status
				❑ M ❑ F	❑ S ❑ M ❑ D ❑ W

Social Security Number	Employing Agency	Employer Group	Your Current Status
		❑ UT ❑ TBR ❑ State ❑ Local Ed ❑ Local Gov	❑ Active ❑ COBRA

Home Address	❑ Update my address	City	ST	ZIP Code	County

Part 3: Health Coverage Selection

Select a Benefit Option
- ❑ Standard PPO
- ❑ Partnership PPO
- ❑ Limited PPO (available to local government only)

Select a Carrier
- ❑ BlueCross BlueShield Network S
- ❑ CIGNA Open Access Plus

Select Region Where You Live or Work
- ❑ East
- ❑ Middle
- ❑ West

See page 4 for map and information for out of state residents

Select a Health Premium Level
- ❑ employee only
- ❑ employee + spouse + child(ren)
- ❑ employee + spouse
- ❑ employee + child(ren)

Part 4: Dental Coverage Selection

Select a Plan
- ❑ Delta Preferred Dental Organization
- ❑ Assurant Prepaid Plan

Check with your agency to see if you are eligible for dental coverage

Select a Dental Premium Level
- ❑ employee only
- ❑ employee + spouse
- ❑ employee + spouse + child(ren)
- ❑ employee + child(ren)

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
			❑ 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 (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

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

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 — 2011

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.

Special Enrollment Qualifying Events

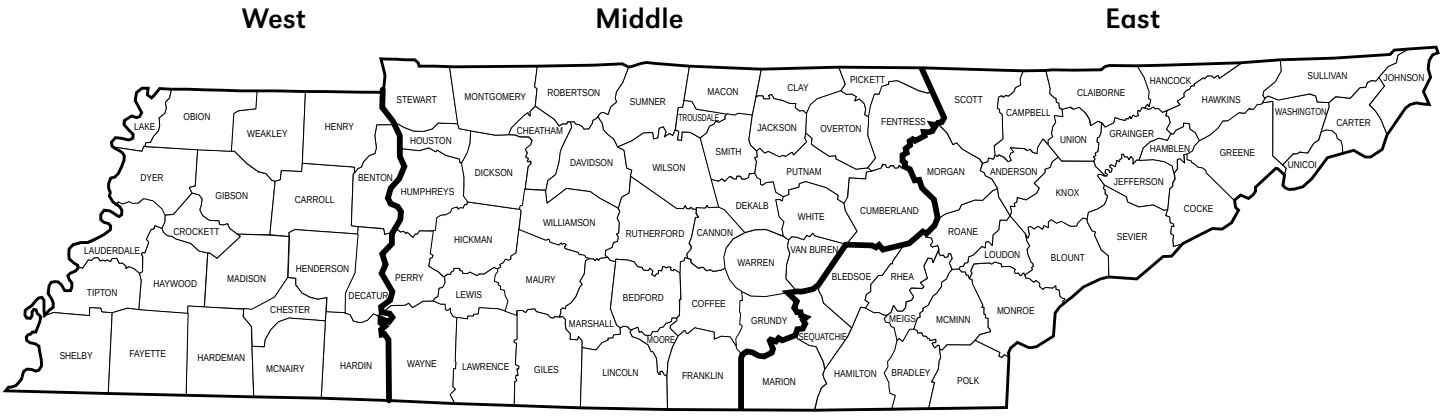
The federal law, Health Insurance Portability Accountability Act (HIPAA) allows employees and dependents to enroll in health coverage under certain conditions. Exceptions will also be made for eligible employees or dependents if they lose their health coverage offered through the employer of the employee's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

QUALIFYING EVENT	DOCUMENTATION REQUIRED
❑ 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.
❑ 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.
❑ 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.
❑ 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.
❑ 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.
❑ 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.
❑ 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.
❑ 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.
❑ 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 **add other previously eligible dependents** to coverage at the same time. This is considered a qualifying event and the documentation listed below will also be required.	
❑ Acquires a new dependent — spouse (**and** adding other previously eligible dependents)	Copy of marriage certificate.
❑ Acquires a new dependent — newborn (**and** adding other previously eligible dependents)	Copy of birth certificate for newborn.
❑ Acquires a new dependent — adoption/legal custody (**and** 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 or subsequent month following approval by Benefits Administration; (4) the day on which the event occurred, if enrollment is waived due to marriage, birth, adoption or placement for adoption; (5) the first of the month following the 60-day period. 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.

2011 PARTNERSHIP PROMISE

By choosing the Partnership PPO and signing the Health / Dental Enrollment Change Application, I agree to the terms and conditions of the Partnership Promise. Under the Partnership Promise, I will:

(1) Complete the health questionnaire.
(2) Complete a health screening at a worksite screening event or at my doctor's office.
(3) Get appropriate preventive and routine health care services.

Also, I promise to do items (1) and (2) above by June 30, 2011.

By making the Partnership Promise, I am eligible to join the Partnership PPO. I know that the Partnership Promise is a serious commitment on my part.

If I do not keep my promise, then I must enroll in the Standard PPO the next year.

If my spouse is covered under the plan, I know that we have to make the same choice. This means that we both have to be in the Partnership PPO - or we both have to be in the Standard PPO. For us to be in the Partnership PPO, my spouse must also make the Partnership Promise.

Our family is not eligible for the Partnership PPO if my covered spouse will not make the Partnership Promise. If I do not or my covered spouse does not fulfill our promise, then our entire family must enroll in the Standard PPO for the next year.

You acknowledge that you agree to abide by the Partnership Promise by choosing the Partnership PPO and signing the Health / Dental Enrollment Change Application.