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 3 FOR INSTRUCTIONS

| TYPE OF ACTION | COVERAGE | PARTICIPANTS AFFECTED | REASON FOR THIS ACTION | | |
|---|---|---|---|---|---|
| ❑ Add coverage | ❑ Health | ❑ Employee | ❑ New Hire/Newly Eligible | Life Event | Special Enrollment (also complete pg 3) |
| ❑ Change coverage | ❑ Dental | ❑ Spouse | ❑ Court Order | ❑ Marriage | ❑ Death |
| **Form not for cancellation** | ❑ Vision | ❑ Child(ren) | ❑ Other _____ | ❑ Newborn | ❑ Divorce |
| | ❑ Disability | | | ❑ Legal Guardianship | ❑ Loss of Eligibility |
| | | | | ❑ Adoption | |

## 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: ❑ HED ❑ 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 — CHOOSE CAREFULLY. EXCEPT FOR QUALIFYING EVENTS, CHANGES ARE NOT ALLOWED OUTSIDE THIS PLAN'S ANNUAL ENROLLMENT.

| SELECT AN OPTION | LOCAL ED & GOV ONLY MAY ALSO CHOOSE | EMPLOYEE HSA CONTRIBUTION (STATE ONLY) | SELECT A CARRIER & NETWORK | SELECT A HEALTH PREMIUM LEVEL |
|---|---|---|---|---|
| ❑ Premier PPO | ❑ Limited PPO | Annual contribution | ❑ BCBS Network S | ❑ employee only |
| ❑ CDHP/HSA (state) | ❑ Local CDHP/HSA | $_____ | ❑ BCBS Network P* | ❑ employee + child(ren) |
| ❑ Standard PPO | | | ❑ Cigna LocalPlus | ❑ employee + spouse |
| | | | ❑ Cigna Open Access* | ❑ employee + spouse + child(ren) |
| | | | *higher premium applies | |

## PART 4: DENTAL COVERAGE SELECTION

| SELECT A PLAN | SELECT A DENTAL PREMIUM LEVEL |
|---|---|
| ❑ Delta Dental DPPO | ❑ employee only |
| ❑ Cigna DHMO (Prepaid) | ❑ employee + child(ren) |
| | ❑ employee + spouse |
| | ❑ employee + spouse + child(ren) |

## PART 5: VISION COVERAGE SELECTION

| SELECT A PLAN | SELECT A VISION PREMIUM LEVEL |
|---|---|
| ❑ Basic Plan | ❑ employee only |
| ❑ Expanded Plan | ❑ employee + child(ren) |
| | ❑ employee + spouse |
| | ❑ employee + spouse + child(ren) |

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

| SHORT TERM DISABILITY | LONG TERM DISABILITY (ST ONLY) |
|---|---|
| ❑ 60%/14 day Elimination Period | ❑ 60%/90 day Elim Period |
| ❑ 60%/30 day Elimination 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 the information above is true. I understand my health, dental and vision selections are effective until the end of the plan year (December 31) subject to plan eligibility criteria, and that I cannot change insurance plans or carriers during the plan year. If I experience a qualifying event mid-year, I may be eligible for changes in enrollment of plan members and dependents as a special enrollment. I understand that submission of fraudulent information may lead to consequences including cancellation of insurance, disciplinary action from my employer, or possible criminal penalties. I understand that if my dependent loses eligibility, it is my responsibility to notify my benefits coordinator, and coverage will terminate at the end of the month in which the loss of eligibility occurs. I understand that I will be held responsible for any claims paid in error.

❑ 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 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.**