RESET

STATE OF TENNESSEE GROUP INSURANCE PROGRAM

2013 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

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

Type of Action
- ☐ Add Coverage
- ☐ Change Coverage
- ☐ Terminate Coverage

Coverage Affected
- ☐ Health
- ☐ Dental
- ☐ Vision

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	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 + child(ren)
- ☐ employee + spouse
- ☐ employee + spouse + child(ren)

Part 4: Dental Coverage Selection

Select a Plan
- ☐ Delta PDO
- ☐ Assurant Prepaid

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: 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 7: 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 one calendar month. If I do not, then I will have to pay the plan back for all of my dependent's healthcare 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 (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	(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

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)
		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 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; **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.

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Employee Name	Edison ID	OR	SSN

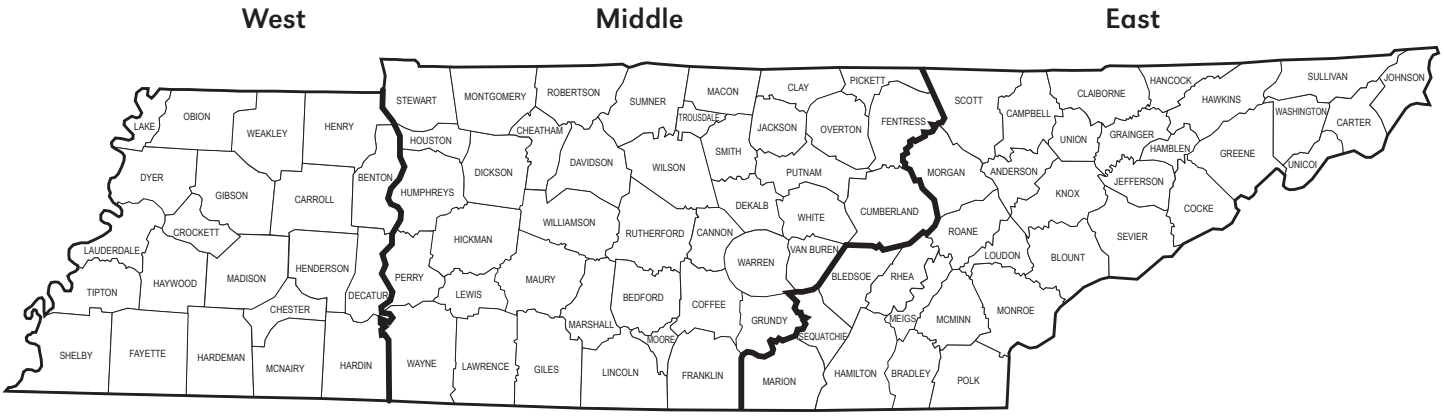
Special Enrollment Qualifying Events

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 coverage. If you are adding dependents to your existing coverage, you and your dependents may transfer to a different carrier or PPO 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 which caused the loss of other coverage for you and your eligible dependents. You must submit this page with the appropriate required documentation, proof of prior coverage and a completed enrollment change 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 and date coverage ended	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 and the reason why coverage ended	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 and the reason for the loss of eligibility	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 and stating that the lifetime maximum has been met	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 and reason why coverage ended	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 and date coverage ended	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 and reason why coverage ended	Day after loss of coverage OR first day of the month following loss of other coverage
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	Date of marriage OR first day of the month following marriage
❑ Acquires a new dependent – newborn (**and** adding other previously eligible dependents)	Copy of birth certificate for newborn	Date of birth
❑ Acquires a new dependent – adoption/ legal custody (**and** adding other previously eligible dependents)	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 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, dental or vision coverage during the Annual Enrollment Transfer Period (AETP), 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 transfer 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.

2013 PARTNERSHIP PROMISE

Members and covered spouses must:

- Complete the online Healthways Well-Being Assessment™ (health questionnaire) **by March 15, 2013**
- Engage in one ParTNers for Health wellness activity **by July 15, 2013**
- Keep your contact information current with your employer
- Engage in the tobacco cessation program if you are a tobacco user

Members and covered spouses identified as at risk must also:

- Complete a biometric screening at your health care provider's office **between July 15, 2012, and July 15, 2013**
- Participate in health coaching and/or case management, if identified in 2013

New employees (as of 1/1/13) will be required to complete the online Well-Being Assessment and biometric screening within 120 days of their insurance coverage effective date.

Visit our website at www.partnersforhealthtn.gov for more information about the Partnership Promise.

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. 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.