STATE OF TENNESSEE GROUP INSURANCE PROGRAM

ENROLLMENT/CHANGE APPLICATION — LOCAL EDUCATION PLAN

State of Tennessee • Department of Finance and Administration • Benefits Administration
26th Floor, William R. Snodgrass TN Tower • Nashville, Tennessee 37243 • 615.741.3590 or 1.800.253.9981 • Fax: 615.741.8196

See back for complete instructions. You must sign and date this form, even if refusing coverage. Please print clearly.

Part 1 — Enrollment or Change Request (check all that apply)

ADD	CHANGE	TERMINATE	REASON
❑ Health ❑ Dental ❑ New Hire ❑ Newly Eligible Employee ❑ Special Enrollment Provision ❑ Medical Underwriting ❑ Spouse ❑ Child(ren)	❑ Name and/or Address ❑ Marital Status ❑ Health Plan* ❑ Dental Plan* ❑ Type of Health Coverage* ❑ Type of Dental Coverage* *indicate change in Part 4	❑ Coverage: self ❑ Coverage: spouse ❑ Coverage: child **PLAN** ❑ Health ❑ Dental	❑ Terminate employment ❑ Employee request ❑ Divorce ❑ Child age ❑ Child married ❑ Child no longer student ❑ Child no longer claimed on federal income tax ❑ Death
Effective ______	Date of change ______	Termination Date ______	

Part 2 — Employee Information (must be completed, even if refusing coverage)

Last Name	First Name	MI	SSN	Date of Birth
Gender ❑ M ❑ F / Marital Status ❑ S ❑ M ❑ D ❑ W	Employee ID (if known)	Employing Department		
Home Address	City	State	Zip Code	County
If your spouse is a participant in the state group insurance program, provide the following:	Spouse Name	SSN	Department	

Part 3 — Dependent Information (see back for definitions, attach a separate sheet if necessary)

Social Security Number	Name Last, First, MI	Birthdate mm/dd/yy	Relationship	Gender	Acquire date	Student (age 19-24)	Coverage Health	Coverage Dental
				❑ M ❑ F		❑ Y ❑ N		
				❑ M ❑ F		❑ Y ❑ N		
				❑ M ❑ F		❑ Y ❑ N		
				❑ M ❑ F		❑ Y ❑ N		

If your dependents (spouse and children) reside at an address other than yours, please provide this information on an attachment

Part 4 — Enrollment Information

HEALTH	COVERAGE TYPE	DENTAL	COVERAGE TYPE
❑ POS ❑ East ❑ Middle ❑ West ❑ PPO ❑ HMO* ❑ Memphis ❑ Nashville ❑ East TN	❑ Single ❑ Family	❑ Prepaid* ❑ PPO	❑ Employee only ❑ Employee + 1 ❑ Employee + 2 or more

*Additional form needed. Please contact your agency benefits coordinator.

Part 5 — Authorization

❑ ACCEPT I confirm that all of the information provided above is accurate. I understand that knowingly providing false and/or misleading information may subject me to disciplinary and/or legal action and may result in loss of insurance coverage. I authorize health care providers to furnish the insurance carrier with all medical, admission, and insurance records pertaining to me and my dependents. I understand that if my dependent(s) become ineligible for coverage that I must report the change to my benefits coordinator within five working days. I understand that all claims paid for ineligible dependents will be recovered. As the policy holder, I am responsible for claims payments to my ineligible dependents.

❑ REFUSAL I have been given the opportunity by my employer to apply for the group insurance program and after due consideration, 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 enrollment provision or prove insurable through medical underwriting. **I understand that the state does not have an open enrollment period for health coverage.**

I am currently enrolled in another health insurance plan: ❑ Yes ❑ No
A certificate of coverage letter must be provided to be exempt from the preexisting condition requirement.
I acknowledge receipt of my insurance handbook and accept all the terms and conditions contained therin.

Employee Signature	Date	Work Phone	Home Phone

OFFICIAL USE ONLY — TO BE COMPLETED BY AGENCY BENEFITS COORDINATOR (active employees only)

Original Hire Date	Coverage Begin Date	Reason	County of Work
Benefit Coordinator Signature		Phone	Date

OFFICIAL USE ONLY — TO BE COMPLETED BY BENEFITS ADMINISTRATION

Employee ID	Class	Pay Group	Position Number	Annual Salary

INSTRUCTIONS

PART 1 ENROLLMENT OR CHANGE REQUEST

Add:	Check all appropriate boxes and include effective date. Effective date must be the first of the month.
Change:	Check desired change and include effective date. Effective date must be the first of the month.
Terminate/Plan:	Check all coverages to be cancelled. Effective date of termination is the last day of the month in which the event causing termination occurred.
Reason:	Check the appropriate reason for termination.

NOTE: If completing the form for enrollment changes only (not a new enrollment), complete your name, social security number, employee ID (if known), and employer name. Then complete only the information you wish to change.

PART 2 EMPLOYEE INFORMATION

Complete each line in full. If your spouse is covered through the State, Local Education or Local Government Plan, please complete the requested information about him/her.

PART 3 DEPENDENT INFORMATION

Refer to your insurance handbook for dependent eligibility rules. If you elect to cover dependents, you must provide all information requested in Part 3 for each dependent. You must provide a social security number for any dependent two years of age or older. If your dependents (spouse and children) reside at an address other than yours, please provide this information on an attachment.

RELATIONSHIP	ACQUIRE DATE
Legally married spouse	Date of marriage
Natural child	Date of birth
Legally adopted child	Date of placement for adoption
Stepchild for whom you or your spouse has legal or joint custody or shared parenting	Date custody obtained or marriage date
Any child living in your home for whom you are the legal guardian	Date appointed guardian
Any child you claim as a dependent for federal income tax	Date you were able to claim child

IMPORTANT: It is your responsibility to notify your benefits coordinator of any changes in the eligibility status of a dependent.

The following are *not eligible* for coverage as your dependent through the state group insurance program:

- Ex-spouse (even if court ordered)
- Parents of the employee or spouse
- Children in the armed forces on a full-time basis
- Children over age 24 (unless they meet qualifications for incapacitation)
- Married children, regardless of age
- Foster children
- Live-in companions not legally married to the employee

Acquire dates are needed solely for the purposes of determining eligibility.

STUDENT: Check yes or no for any unmarried dependent child older than 18 years and 11 months of age. A full-time student is one who is registered for at least the number of credit hours that the institution requires in its definition of full-time student status and who attends classes for two of three semesters or three of four quarters in any 12-month period.

COVERAGE HEALTH/DENTAL: Check block(s) to show coverage selected for each dependent.

PART 4 ENROLLMENT INFORMATION

Health:	Check the appropriate box for the HMO service area for which you are enrolling. A physician selection card must also be completed. If enrolling in a POS, check the box beside the appropriate service area. Eligibility for an HMO or POS is based on your county of work or residence. These service areas are listed in the *Medical Plans Comparison Summary* brochure. If enrolling in the PPO or POS, a certificate of coverage letter must be provided to be exempt from the preexisting condition requirement.
Type of Coverage:	Single covers employee only. Family covers employee and all eligible dependents.
Dental:	Optional dental coverage is only available if offered through your agency. A dentist selection card must be completed for the prepaid plan.

Anytime you elect to cover dependents, you must complete PART 3.

PART 5 AUTHORIZATION

Check a block either accepting or refusing coverage. You must complete Parts 2 and 5, even if refusing coverage. Sign and date the form.

Benefits Administration does not support any practice that excludes participation in programs or denies the benefits of such programs on the basis of race, color or national origin. If you have a complaint regarding discrimination, please call 1.866.576.0029 or 615.741.4517.