RESET

STATE OF TENNESSEE GROUP INSURANCE PROGRAM

ANNUAL ENROLLMENT APPLICATION FOR RETIREE PARTICIPANT

State of Tennessee • Department of Finance and Administration • Benefits Administration
312 Rosa L. Parks Avenue, 19th Floor • Nashville, Tennessee 37243 • 800.253.9981 • fax 615.741.8196

PARTNERS FOR HEALTH

Completed form (blue or black ink) must be postmarked or faxed to Benefits Administration by 10/28/22 — Attention: Retirement

PART 1: RETIREE INFORMATION

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NUMBER OR EDISON ID

DATE OF BIRTH	GENDER	MARITAL STATUS	ARE YOU THE SURVIVING SPOUSE OF A DECEASED RETIREE?	AGENCY RETIRED FROM
	❑ M ❑ F		❑ Yes ❑ No	

HOME ADDRESS	CITY	ST	ZIP CODE	COUNTY

PART 2: HEALTH COVERAGE SELECTION

❑ Add
❑ Change
❑ Cancel

❑ Retiree
❑ Spouse
❑ Child

SELECT A BENEFIT OPTION
❑ Premier PPO
❑ Standard PPO
❑ CDHP/HSA or Local CDHP/HSA
❑ Limited PPO (local education and local government only)

SELECT A CARRIER & NETWORK
❑ BCBS Network S
❑ BCBS Network P*
❑ Cigna LocalPlus
❑ Cigna Open Access*
*higher premium applies

SELECT A PREMIUM LEVEL
❑ retiree only
❑ retiree + child(ren)
❑ retiree + spouse
❑ retiree + spouse + child(ren)
❑ spouse ONLY
❑ child(ren) ONLY
❑ spouse + child(ren) ONLY

PART 3: DENTAL COVERAGE SELECTION

❑ Add
❑ Change
❑ Cancel

❑ Retiree
❑ Spouse
❑ Child

SELECT PLAN
❑ Delta Dental DPPO
❑ Cigna DHMO (Prepaid Provider)

SELECT A PREMIUM LEVEL
❑ retiree only
❑ retiree + child(ren)
❑ retiree + spouse
❑ retiree + spouse + child(ren)

PART 4: VISION COVERAGE SELECTION (must be on health coverage)

❑ Add
❑ Change
❑ Cancel

❑ Retiree
❑ Spouse
❑ Child

SELECT PLAN
❑ Basic
❑ Expanded

SELECT A PREMIUM LEVEL
❑ retiree only
❑ retiree + child(ren)
❑ retiree + spouse
❑ retiree + spouse + child(ren)
❑ spouse ONLY
❑ child(ren) ONLY
❑ spouse + child(ren) ONLY

PART 5: DEPENDENT INFORMATION — LIST ALL DEPENDENTS YOU WISH TO COVER (attach a separate sheet if necessary)

SOCIAL SECURITY NUMBER	NAME (LAST, FIRST, MI)	BIRTHDATE	GENDER	RELATIONSHIP	ACQUIRE DATE *	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.
❑ A separate sheet with more dependents is attached

PART 6: RETIREE AUTHORIZATION

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 eligibility, 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 or possible criminal penalties. If my dependents lose eligibility, I know that I must tell Benefits Administration within one calendar month. I understand that I will be responsible for any claims paid in error.

RETIREE SIGNATURE	DATE	HOME PHONE