



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



Completed form (blue or black ink) must be postmarked or faxed to Benefits Administration by 10/27/23 — Attention: Retirement

PART 1: RETIREE INFORMATION										
LAST NAME			FIRST NAME		MI	SOCIAL SECURITY NUMBER OR EDISON ID				
DATE OF BIRTH	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS	ARE YOU THE SURVIVING SPOUSE OF A DECEASED RETIREE? <input type="checkbox"/> Yes <input type="checkbox"/> No			AGENCY RETIRED FROM				
HOME ADDRESS			CITY		ST	ZIP CODE	COUNTY			
PART 2: HEALTH COVERAGE SELECTION										
<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Cancel	<input type="checkbox"/> Retiree <input type="checkbox"/> Spouse <input type="checkbox"/> Child	SELECT A BENEFIT OPTION <input type="checkbox"/> Premier PPO <input type="checkbox"/> Standard PPO <input type="checkbox"/> CDHP/HSA or Local CDHP/HSA <input type="checkbox"/> Limited PPO (local education and local government only)			SELECT A CARRIER & NETWORK <input type="checkbox"/> BCBS Network S <input type="checkbox"/> BCBS Network P* <input type="checkbox"/> Cigna LocalPlus <input type="checkbox"/> Cigna Open Access* <small>*higher premium applies</small>		SELECT A PREMIUM LEVEL <input type="checkbox"/> retiree only <input type="checkbox"/> retiree + child(ren) <input type="checkbox"/> retiree + spouse <input type="checkbox"/> retiree + spouse + child(ren)			<input type="checkbox"/> spouse ONLY <input type="checkbox"/> child(ren) ONLY <input type="checkbox"/> spouse + child(ren) ONLY
PART 3: DENTAL COVERAGE SELECTION					PART 4: VISION COVERAGE SELECTION (must be on health coverage)					
<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Cancel	<input type="checkbox"/> Retiree <input type="checkbox"/> Spouse <input type="checkbox"/> Child	SELECT PLAN <input type="checkbox"/> Delta Dental DPPO <input type="checkbox"/> Cigna DHMO (Prepaid Provider)			<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Cancel	<input type="checkbox"/> Retiree <input type="checkbox"/> Spouse <input type="checkbox"/> Child	SELECT PLAN <input type="checkbox"/> Basic <input type="checkbox"/> Expanded			
SELECT A PREMIUM LEVEL <input type="checkbox"/> retiree only <input type="checkbox"/> retiree + child(ren) <input type="checkbox"/> retiree + spouse <input type="checkbox"/> retiree + spouse + child(ren)					SELECT A PREMIUM LEVEL <input type="checkbox"/> retiree only <input type="checkbox"/> retiree + child(ren) <input type="checkbox"/> retiree + spouse <input type="checkbox"/> retiree + spouse + child(ren) <input type="checkbox"/> spouse ONLY <input type="checkbox"/> child(ren) ONLY <input type="checkbox"/> 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 <input type="checkbox"/> M <input type="checkbox"/> F	RELATIONSHIP	ACQUIRE DATE *	HEALTH <input type="checkbox"/>	DENTAL <input type="checkbox"/>	VISION <input type="checkbox"/>	
				<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
				<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
				<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
* 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. <input type="checkbox"/> 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, I may be eligible for changes in enrollment of plan members and dependents. 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 if I fail to notify.										
RETIREE SIGNATURE				DATE		HOME PHONE				