Reset

KEYED: _____
VERIFIED: _____

PER# _____

STATE OF TENNESSEE GROUP INSURANCE PROGRAM

ENROLLMENT CHANGE APPLICATION

University of Tennessee • Payroll, Benefits and Retirement • Benefits Administration
505 Summer Place - UT Tower 907 • Knoxville, TN 37902 • 865.974.5251 • utinsurance@tennessee.edu

PARTNERS FOR HEALTH

PART 1: ACTION REQUESTED — PLEASE SEE PAGE 3 FOR INSTRUCTIONS

TYPE OF ACTION
- ❑ Add coverage
- ❑ Change coverage

Form not for cancellation

COVERAGE
- ❑ Health
- ❑ Dental
- ❑ Vision
- ❑ Disability

PARTICIPANTS AFFECTED
- ❑ Employee
- ❑ Spouse
- ❑ Child(ren)

REASON FOR THIS ACTION
- ❑ New Hire/Newly Eligible
- ❑ Court Order
- ❑ Other _____

Life Event
- ❑ Marriage
- ❑ Newborn
- ❑ Legal Guardianship
- ❑ Adoption

Special Enrollment (also complete pg 3)
- ❑ Death
- ❑ Divorce
- ❑ Loss of Eligibility

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
	University of Tennessee	☑ HED ☐ ☐ ☐	☑ Active ☐

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
- ❑ Premier PPO
- ❑ CDHP/HSA (state)
- ❑ Standard PPO

SELECT A CARRIER & NETWORK
- ❑ BCBS Network S
- ❑ BCBS Network P*
- ❑ Cigna LocalPlus
- ❑ Cigna Open Access*

*higher premium applies

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 Dental DPPO
- ❑ Cigna DHMO (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: DISABILITY SELECTION (ST/UT/TBR)

SHORT TERM DISABILITY
- ❑ 14 day Elimination Period
- ❑ 30 day Elimination Period

LONG TERM DISABILITY
- ☐ Complete the separate Lincoln Natl. form included in the New Employee Info Packet

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
				❑ PPACA Eligible ❑ 1450 Eligible

AGENCY BENEFITS COORDINATOR SIGNATURE	DATE

Active employees should return this completed form to your agency benefits coordinator. COBRA participants should send to Benefits Administration.

RESET

STATE OF TENNESSEE GROUP INSURANCE PROGRAM

BASIC LIFE INSURANCE BENEFICIARY DESIGNATION APPLICATION

University of Tennessee • Payroll, Benefits and Retirement • Benefits Administration
505 Summer Place - 907 UT Tower • Knoxville, TN 37902 • 865.974.5251 • utinsurance@tennessee.edu

TYPE OF REQUEST

- ☐ New Enrollment
- ☐ Beneficiary Add/Change

Effective date of designation: _____

Enrolled in health coverage:
☐ Yes ☐ No

If yes, type of health coverage:
- ☐ Employee only
- ☐ Employee + dependents

This application is to be used to designate a beneficiary for basic life insurance coverages. Individuals who elect **NOT** to enroll in health insurance will be provided with basic term life and basic accident coverage with the premium being provided by the State of Tennessee. These amounts of coverage **CANNOT** be increased.

Individuals who **DO** elect health coverage will also receive the same state support; however, the amount of coverage will increase as your salary increases, with additional premiums deducted from your paycheck. If enrolling in health coverage, covered dependents will also receive life insurance benefits; however, the amount of coverage is different from that of an employee.

Please refer to the eligibility and enrollment guide for further information.

EMPLOYEE INFORMATION

NAME	SOCIAL SECURITY NUMBER	EDISON ID (IF KNOWN)	
DEPARTMENT WHERE EMPLOYED		DATE OF HIRE	DATE OF BIRTH
WORK ADDRESS (NOT REQUIRED)	CITY	STATE	ZIP CODE
HOME ADDRESS	CITY	STATE	ZIP CODE
MARITAL STATUS ☐ Single ☐ Married ☐ Divorced ☐ Widowed	GENDER ☐ Male ☐ Female	DAYTIME PHONE NUMBER	

AUTHORIZATION

I understand that this enrollment is NOT for health insurance coverage and is for basic term life and basic accident coverage only. Unless I enroll in family health insurance, coverage is provided to the employee only (not spouse or child). If I enroll in family health insurance coverage, my covered dependents will also be enrolled in basic life coverage; however dependents do not elect a beneficiary as the benefit will automatically default to me as the employee. I further understand that a new application must be completed and returned to my agency benefits coordinator any time I want to designate a new beneficiary. Failure to designate a beneficiary will result in the proceeds being paid to my spouse, children, parents or estate according to applicable contract provisions in the event of my death.

I authorize the state group insurance program to release information to their life insurance contractor on behalf of myself and all family members (name, address, social security number, age, gender, salary, enrollment effective/termination date) required to establish eligibility and coverage levels for the purpose of obtaining life insurance coverage. This authorization shall be in force for the time period I have a pending application or am enrolled with this life insurance company. The state group insurance program will not condition treatment, payment or enrollment eligibility on the signature of this authorization and may not have the right to control further disclosures of this information.

Upon termination of employment, I may convert my basic term life coverage to an individual policy with the insurance company. Payment of monthly premiums directly to the insurance company will be my responsibility.

I confirm that all information that I have provided on this application is accurate. I understand that providing false and/or misleading information may subject me to disciplinary and/or legal action. I authorize my employer to deduct the required premium from my salary/wages.

_____ _____

EMPLOYEE SIGNATURE DATE

Complete beneficiary designation on back of this application and return to your agency benefits coordinator

NAME	EDISON ID	OR	SSN

PRIMARY BENEFICIARY DESIGNATION

NAME	PHONE NUMBER	SOCIAL SECURITY NUMBER	RELATIONSHIP	PERCENT OF BENEFIT
HOME ADDRESS		CITY	STATE	ZIP CODE
NAME	PHONE NUMBER	SOCIAL SECURITY NUMBER	RELATIONSHIP	PERCENT OF BENEFIT
HOME ADDRESS		CITY	STATE	ZIP CODE
NAME	PHONE NUMBER	SOCIAL SECURITY NUMBER	RELATIONSHIP	PERCENT OF BENEFIT
HOME ADDRESS		CITY	STATE	ZIP CODE
NAME	PHONE NUMBER	SOCIAL SECURITY NUMBER	RELATIONSHIP	PERCENT OF BENEFIT
HOME ADDRESS		CITY	STATE	ZIP CODE
NAME	PHONE NUMBER	SOCIAL SECURITY NUMBER	RELATIONSHIP	PERCENT OF BENEFIT
HOME ADDRESS		CITY	STATE	ZIP CODE
TOTAL FOR PRIMARY BENEFICIARY (MUST BE 100%)				**TOTAL**

CONTINGENT BENEFICIARY DESIGNATION

NAME	PHONE NUMBER	SOCIAL SECURITY NUMBER	RELATIONSHIP	PERCENT OF BENEFIT
HOME ADDRESS		CITY	STATE	ZIP CODE
NAME	PHONE NUMBER	SOCIAL SECURITY NUMBER	RELATIONSHIP	PERCENT OF BENEFIT
HOME ADDRESS		CITY	STATE	ZIP CODE
NAME	PHONE NUMBER	SOCIAL SECURITY NUMBER	RELATIONSHIP	PERCENT OF BENEFIT
HOME ADDRESS		CITY	STATE	ZIP CODE
NAME	PHONE NUMBER	SOCIAL SECURITY NUMBER	RELATIONSHIP	PERCENT OF BENEFIT
HOME ADDRESS		CITY	STATE	ZIP CODE
NAME	PHONE NUMBER	SOCIAL SECURITY NUMBER	RELATIONSHIP	PERCENT OF BENEFIT
HOME ADDRESS		CITY	STATE	ZIP CODE
TOTAL FOR CONTINGENT BENEFICIARY (MUST BE 100%)				**TOTAL**

NOTE: Contingent beneficiary will only receive benefits if all primary beneficiaries are deceased.

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** one document from the additional documents list below:
		Proof of Marital Relationship • Government issued marriage certificate or license • Naturalization papers indicating marital status
		Additional Documents • 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" or "married filing separately" with the name of the spouse provided thereon, submit page 1 of the return with the income figures blacked out
		If just married in the previous 12 months, only a marriage certificate is needed for proof of eligibility
Natural (biological) child under age 26	A natural (biological) child	The child's birth certificate (will accept mother's copy for newborn); **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	Final court order granting adoption; **or**
		International adoption papers from country of adoption; **or**
		Court order placing child in custody of member for purpose of adoption
Child under age 18 for whom the participant is legal guardian	A child under age 18 for whom the participant is the legal guardian	Court order appointing the member a guardian of the child, requiring financial support of the child, mandating insurance coverage of the child, and stating the length of the guardianship
Stepchild under age 26	A stepchild	Verification of marriage between employee and spouse (as outlined above) and birth certificate of the child showing the relationship to the spouse, or documents determined by BA to be the legal equivalent
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.	Certificate of Incapacitation for Dependent Child form must be submitted prior to the dependent's 26th birthday. The insurance carrier will review the form, make a determination, and provide BA with documentation once a determination has been made. If approved for incapacity, the child will continue the same coverage.

Revised 08/21

Never send original documents. Please mark out or black out any social security numbers and any personal financial informationon the copies of your documents BEFORE you return them.

NAME	EDISON ID	OR	SSN

Special Enrollment Qualifying Events

If you or a dependent lose coverage under any other group insurance plan, or if you acquire a new dependent during the plan year, the federal Health Insurance Portability and Accountability Act (HIPAA) may provide additional opportunities for you and eligible dependents to enroll in health coverage. If you are adding dependents to your **existing** coverage, you and eligible dependents may transfer to a different carrier or healthcare option, if eligible. You or eligible dependents may also be eligible to enroll in dental and vision coverage if you meet the requirements stated in the dental or vision certificates of coverage. Premiums are not prorated. If approved, you must pay premium for the entire month in which the effective date occurs.

INSTRUCTIONS: Identify the qualifying event(s) which applies to you or your eligible dependent(s). You must submit this page with the appropriate required documentation, proof of prior coverage and a completed enrollment application.

NOTE: Application for enrollment must be made within 60 days of the loss of eligibility for other health insurance coverage or within 30 days of a new dependent's acquire date. Voluntary actions resulting in loss of coverage (such as voluntary cancellation of coverage and cancellation for not paying premiums) ARE NOT qualifying events. Electing to cancel, waive or decline coverage during another plan's enrollment period IS NOT a qualifying event.

Retroactive coverage (a coverage effective date that begins before an enrollment is completed and submitted to BA) **is not allowed except for birth, adoption and placement for adoption.** For all other events, the earliest effective date allowed for coverage under this plan is the first day of the month following the date that your enrollment request, including all required documentation, is completed and submitted to BA. Enrollment should be completed and submitted to BA as soon as possible to ensure the earliest possible effective date. The examples provided below assume all eligibility requirements are satisfied and that required documentation is submitted with enrollment.

EXAMPLE 1

Marriage date is June 15 (30- day enrollment period applies):

- enrollment submitted to BA on June 25 = 7/1 effective date
- enrollment submitted to BA on July 10 = 8/1 effective date
- enrollment submitted on or after July 16 will exceed the 30-day enrollment period, and your request will be denied

EXAMPLE 2

Loss of other coverage date is June 30 (60-day enrollment period applies):

- enrollment submitted to BA on June 30 = 7/1 effective date
- enrollment submitted to BA on July 10 = 8/1 effective date
- enrollment submitted to BA on August 5 = 9/1 effective date
- enrollment submitted on or after August 30 will exceed the 60-day enrollment period, and your request will be denied

QUALIFYING EVENT	EFFECTIVE DATE	DOCUMENTATION REQUIRED
❑ An event causing the loss of eligibility for coverage from another group health insurance plan*	The effective date is the first day of the first calendar month after the date BA receives the request for special enrollment	Written documentation from an employer, former employer, insurance company, or former insurance company on company letterhead that lists (1) names of covered participants; (2) dates of coverage including your coverage at the time coverage in this plan was declined; (3) types of coverage (medical, dental, vision); (4) each participant that lost eligibility for coverage; (5) the date of loss of eligibility to continue coverage, and (6) the reason why eligibility for coverage was lost
❑ An event that results in acquisition of a new dependent spouse or stepchild acquired by marriage, or a child acquired pursuant to an order of guardianship**	The effective date is the first day of the first calendar month after the date BA receives the request for special enrollment	1. Marriage Certificate 2. Birth Certificate (will accept mother's copy for newborn) 3. Order of Guardianship requiring financial support and provision of insurance coverage, which sets out the date of the guardianship period
❑ An event that results in acquisition of a new dependent acquired by birth, adoption, or placement in legal custody for adoption**	The effective date is the date of birth, adoption, or placement for adoption	1. Birth Certificate (will accept mother's copy for newborn) 2. Final Order of Adoption or Order of Custody in anticipation of adoption

* When eligibility for coverage under other insurance is lost, only the Employee and any dependents who lose the other coverage may enroll.

** When a new dependent is acquired, an Employee may enroll in employee only or family coverage and may add the new dependent and previously eligible dependents (those who were not enrolled when initially eligible and are otherwise still eligible).

The employee and dependents may only enroll in the types of coverage lost (medical/medical; dental/dental; vision/vision).

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 or change health, dental or vision coverage during the annual enrollment period, follow these instructions for each section in Part 1:

TYPE OF ACTION — mark the box indicating that you want to add or change 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 enrollment period mark "Other" and write in AEP

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.

Anti-Discrimination and Civil Rights Compliance

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, national origin, sex, age or disability in its health programs and activities. If you have a complaint regarding discrimination, please call 615-532-9617.

If you think you have been treated in a different way for these reasons, please mail this information to the Civil Rights Coordinator for the Department of Finance and Administration:

- Your name, address and phone number. You must sign your name. (If you write for someone else, include your name, address, phone number and how you are related to that person, for instance wife, lawyer or friend.)
- The name and address of the program you think treated you in a different way.
- How, why and when you think you were treated in a different way.
- Any other key details.

Mail to: State of Tennessee, Civil Rights Coordinator, Department of Finance and Administration, Office of General Counsel, 20th Floor, 312 Rosa L. Parks Avenue, William R. Snodgrass Tennessee Tower, Nashville, TN 37243.

Need free language help? Have a disability and need free help or an auxiliary aid or service, for instance Braille or large print? Please call 615-532-9617.

You may also contact the: U.S. Department of Health & Human Services – Region IV Office for Civil Rights, Sam Nunn Atlanta Federal Center, Suite 16T70, 61 Forsyth Street, SW, Atlanta, Georgia 30303-8909 or 1-800-368-1019 or TTY/TDD at 1-800-537-7697 **OR** U. S. Office for Civil Rights, Office of Justice Programs, U. S. Department of Justice, 810 7th Street, NW, Washington, DC 20531 **OR** Tennessee Human Rights Commission, 312 Rosa Parks Avenue, 23rd Floor, William R. Snodgrass Tennessee Tower, Nashville, TN 37243.

If you speak a language other than English, help in your language is available for free.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-576-0029 (TTY: 1-800-848-0298).

866 (رقم -576-0029- ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1.(800-848-0298- هاتف الصم والبكم: 1

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-866-576-0029 (TTY:1-800-848-0298)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành chobạn. Gọi số 1-866-576-0029 (TTY:1-800-848-0298).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-576-0029 (TTY: 1-800-848-0298) 번으로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-576-0029 (ATS : 1-800-848-0298).

Ni songen mwohmw ohte, komw pahn sohte anahne kawehwe mesen nting me koatoantoal kan ahpw wasa me ntingie [Lokaiahn Pohnpei] komw kalangan oh ntingidieng ni lokaiahn Pohnpei. Call 1-866-576-0029 (TTY: 1-800-848-0298).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-866-576-0029 (መስማት ለተሳናቸው: 1-800-848-0298).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-576-0029 (TTY: 1-800-848-0298).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-866-576-0029 (TTY:1-800-848-0298)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-866-576-0029（TTY:1-800-848-0298）まで、お電話にてご連絡ください。

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-576-0029 (TTY: 1-800-848-0298).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध है। 1-866-576-0029 (TTY: 1-800-848-0298) पर कॉल करें।

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-576-0029 (телетайп: 1-800-848-0298).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما 866-576-0029 (TTY: 1-800-848-0298) فراهم می باشد. با تماس بگیرید