RESET

STATE OF TENNESSEE GROUP INSURANCE PROGRAM

APPLICATION TO CONTINUE INSURANCE AT RETIREMENT

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

PARTNERS FOR HEALTH

You must apply to continue coverage at retirement within one full calendar month of the date active coverage ends

PART 1: ACTION REQUESTED

TYPE OF ACTION	REASON FOR ACTION	PARTICIPANTS AFFECTED	COVERAGE AFFECTED	AGENCY RETIRED FROM	
☐ Add Coverage ☐ Update Personal Info	☐ New Retiree ☐ Surviving Spouse Continuing Coverage	☐ Retiree ☐ Spouse ☐ Child(ren)	☐ Health ☐ Dental ☐ Vision ☐ Medicare Supp	DATE OF RETIREMENT	TERMINATION DATE (SEE PAGE 3)

PART 2: RETIREE INFORMATION

FIRST NAME	MI	LAST NAME	DATE OF BIRTH	GENDER	MARITAL STATUS
				☐ M ☐ F	☐ S ☐ M ☐ D ☐ W

SOCIAL SECURITY NUMBER	ELIGIBLE FOR MEDICARE?	IF YES, MEDICARE PART A EFFECTIVE DATE	MEDICARE PART B EFFECTIVE DATE
	☐ Yes ☐ No		

HOME ADDRESS ☐ UPDATE MY ADDRESS	CITY	ST	ZIP CODE	COUNTY

PART 3: GROUP HEALTH COVERAGE CONTINUATION

CHECK ALL THAT APPLY

☐ retiree ☐ spouse ☐ child(ren)

PART 4: MEDICARE SUPPLEMENT ENROLLMENT

CHECK DESIRED COVERAGE LEVEL

☐ retiree ☐ retiree + spouse
☐ retiree + children ☐ retiree + spouse + child(ren)

PART 5: DENTAL COVERAGE

PLAN

☐ DPPO
☐ Prepaid

CHECK DESIRED COVERAGE LEVEL

☐ retiree ☐ retiree + spouse
☐ retiree + child(ren) ☐ retiree + spouse + child(ren)

PART 6: VISION COVERAGE

PLAN

☐ Basic
☐ Expanded

CHECK ALL THAT APPLY—must be enrolled in group health

☐ retiree ☐ spouse ☐ child(ren)

PART 7: DEPENDENT INFORMATION — attach a separate sheet if necessary

NAME (FIRST, MI, LAST)	DATE OF BIRTH	RELATIONSHIP	GENDER	SOCIAL SECURITY NUMBER	MEDICARE ELIGIBLE?	
			☐ M ☐ F		PART A ☐ Y ☐ N	DATE EFFECTIVE
			☐ M ☐ F		PART A ☐ Y ☐ N	DATE EFFECTIVE
			☐ M ☐ F		PART A ☐ Y ☐ N	DATE EFFECTIVE

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: AUTHORIZATION

I confirm that all of the information above is true. I understand that I must apply to continue coverage within one calendar month of the date my active coverage ends. 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 Benefits Administration 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 healthcare providers to give my insurance carrier the medical and insurance records for me and my dependents. I have read and understand the information and eligibility criteria on page three.

SIGNATURE	DATE	HOME PHONE	EMAIL ADDRESS

PART 9: EMPLOYER CERTIFICATION — MUST BE COMPLETED BY YOUR AGENCY

RETIREE IS: ☐ TCRS ☐ NON-TCRS ☐ ORP/TIAA ☐ FRM LEGIS

PREMIUM: ☐ RET ☐ INS ☐ BIL

TYPE: ☐ ST ☐ LE ☐ LE-SS ☐ LG

ACTIVE CVG TERM DATE	RET CVG EFFECT DATE	YEARS OF CREDITABLE SVC

LENGTH OF PARTICIPATION IN THE PLAN IMMEDIATELY PRIOR TO TERMINATION OF EMPLOYMENT: ☐ 3 OR MORE YEARS ☐ 1-3 YEARS ☐ LESS THAN 1 YEAR

NAME OF AGENCY	AGENCY SIGNATURE	DATE	PHONE NUMBER

Please complete in blue or black ink and return completed form 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) or form 8879 (electronic filing)
		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; **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 (as outlined above) 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

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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.

Instructions

Members who meet the eligibility rules to continue health insurance at retirement for themselves or covered eligible dependents must submit an application within one full calendar month of the date active coverage ends. If you do not submit the paperwork within this time frame the only way you can later enroll in the retirement plan would be to meet the special qualifying event criteria.

PART 1: This section should be completely filled out by the retiree and the separating agency. For TCRS members, the date of retirement is the effective date of your retirement with the Tennessee Consolidated Retirement System. The termination date of employment is either the last day in an active paid status or the last day of an approved leave of absence, whichever is later. This date must be confirmed by your separating agency and is certified by your agency benefit coordinator signing the employer certification section of this form.

PART 2 RETIREE INFORMATION: This section must completed by the retiree. If you are a surviving spouse who is continuing coverage as the new head of contract on the retiree plan, please complete the application with your information as the retiree. If you are entitled to Medicare you must submit a copy of your Medicare card with this application.

PART 3 GROUP HEALTH: Eligibility requirements to continue group health coverage for retirees and their dependents are outlined in the State Plan Document. Requirements for State and Higher Education retirees can be found in Section 4.07. Local Education and Local Government retiree's eligibility requirements are outlined in Section 4.06 of the respective Plan Documents. The plan documents can be viewed at tn.gov/finance.

PARTNERSHIP PROMISE

Enrollment in Partnership PPO. By choosing the Partnership PPO, you and your dependent spouse (if applicable), agree to the Partnership Promise requirements each year that you are enrolled. During the fall enrollment period each year you may select another health insurance option.

Requirements of the Partnership PPO. You will be informed of the requirements of the Partnership Promise on or before the fall enrollment period each year. The benefits of the Partnership Promise are open to all plan members. If you think you might be unable to fulfill the Partnership Promise, call our ParTNers for Health Wellness Program at 888.741.3390, and they will work with you and/or your physician, if you wish, to find an alternate way for you to meet the Promise.

If you do not meet the Partnership Promise. If you, or your dependent spouse, do not complete the requirements of the Partnership Promise, you and all of your covered dependents can stay in your current plan, but you could pay more for the Partnership PPO plan the following 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.

I further understand per the eligibility requirements as outlined in the state plan documents, State/Higher Education section 4.06 and Local Education section 4.05 that if I am a retiree who qualifies to continue group health coverage and either myself or a covered dependent becomes entitled to Medicare Part A prior to the age of 65, the retiree and/or their covered Medicare Part A eligible dependent must enroll in Part B in order to maintain group health coverage until entitled to Medicare by virtue of age. You must submit a copy of your Medicare card to Benefits Administration as documentation you have enrolled in Part A and B. If the pre 65 Medicare entitled retiree or retiree dependent does not enroll in Medicare Part B when eligible coverage under the state group health plan will be terminated.

LOCAL GOVERNMENT retirees and dependents who become entitled to Medicare Part A are NOT eligible for coverage under the retiree group health plan as referenced in section 4.05 of the Local Government plan document.

In all cases, it is the responsibility of the retiree to notify Benefits Administration within 5 working days if the retiree or a covered dependent has become eligible for Medicare prior to the age of 65.

PART 4 MEDICARE SUPPLEMENT: To be eligible for the TN Plan Medicare Supplement policy you must be receiving a monthly TCRS or Higher Education ORP retirement benefit and the retiree and the dependent they wish to cover must be enrolled in at least Medicare Part A. You must submit a copy of your Medicare card with this application. The TN Plan will not pay if you are not enrolled in Medicare. If you only enroll in Medicare Part A, the TN Plan will pay after Medicare for Part A expenses but will not pay for Medicare Part B expenses. In addition, the TN Plan will not pay behind or coordinate benefits if you have enrolled in a Medicare HMO or Medicare Advantage plan. The TN Plan does not offer any pharmacy benefits. You must enroll in Medicare Part D or subscribe to another supplemental for pharmacy needs. If you are enrolled in TennCare you do not need Medicare supplement coverage. This enrollment form must be completed within 60 days of initial eligibility which is either the date you become eligible for Medicare, your date of retirement or the effective date of loss of creditable group health coverage; whichever is later.

If you are applying 60 days or more past your initial eligibility date, you must apply as a late applicant and enrollment will be subject to approval. If you are a late applicant, please contact Benefits Administration for Medicare supplement late applicant information.

PART 5 DENTAL: To be eligible to apply for retiree dental you MUST receive a monthly TCRS or higher education ORP benefit. If you do not apply within one full calendar month of your active group health insurance and/or dental benefits termination the effective date of your coverage will be the first of the following month in which you apply. If you select the Prepaid dental plan please note that you MUST select a dentist who participates in the network. The Prepaid plan will not pay any benefits if you do not select and use a participating network dentist. Once your coverage has changed from active to retiree you MUST contact the carrier to confirm your continued use of your selected participating network dentist. Additional information on retiree dental and COBRA dental can be obtained from your agency benefits coordinator or viewed at tn.gov/finance.

PART 6 VISION: To be eligible to apply for vision you MUST receive a monthly TCRS or higher education ORP benefit and be enrolled in group health coverage.

PART 7 DEPENDENT INFORMATION: This section must be completed if you are applying to cover a dependent. You must complete the Medicare eligibility information in this section and submit a copy of your dependent's Medicare card. If you have not previously submitted dependent verification documentation on a dependent you are applying to cover, please submit the applicable documentation with this application as outlined on page 2.

PART 8 RETIREE AUTHORIZATION: This section must be signed and dated by the retiree (or surviving spouse if they are the new head of contract). If the retiree has a designated power of attorney, a copy of the POA must be attached to this application.

PART 9 EMPLOYER CERTIFICATION: The designated official with the separating agency must complete and certify if the retiree is a TCRS member, a non-TCRS retiree, a higher education ORP retiree or a former legislator. The correct premium collection method should also be designated:

- RET = premiums will be collected from the TCRS pension check
- INS = Benefits Administration has agreed to bill the agency for retiree premiums
- BIL = the retiree will be billed directly at home by Benefits Administration

Type of retiree must also be completed:

- ST = State
- LE = Local Education teacher/certified staff
- LE-SS = Local Education support staff
- LG = Local Government

Active coverage term date indicates the date an active employee's insurance is terminate. Years of creditable service must be certified by agency for non-TCRS, ORP and former legislators. The agency should also review and mark on the form the applicable time frame the retiree has been continuously covered on the plan immediately preceding termination of employment. The form must be signed and dated by the designated agency official. By signing the employer certification section the agency is also certifying the correct term date of employment and date of retirement has been completed in Part 1.