RESET

KEYED:_____

VERIFIED:_____

Personnel #

_____ M / B

STATE OF TENNESSEE GROUP INSURANCE PROGRAM

2021 ENROLLMENT CHANGE APPLICATION

University of Tennessee • Payroll and Benefits • Benefits Administration

P115 Andy Holt Tower • Knoxville, TN 37996 • 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
- ☐ Short Term 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
- ☐ BlueCross BlueShield Network S
- ☐ Cigna LocalPlus
- ☐ Cigna Open Access (surcharge applies)

REGION OF THE STATE WHERE YOU LIVE OR WORK
- ☐ East
- ☐ Middle
- ☐ West

SELECT A HEALTH PREMIUM LEVEL
- ☐ employee only
- ☐ employee + child(ren)
- ☐ employee + spouse
- ☐ employee + spouse + child(ren)

PART 4: DENTAL COVERAGE SELECTION

SELECT A PLAN
- ☐ MetLife DPPO
- ☐ Cigna Prepaid DHMO

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 (UT)

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

LONG TERM DISABILITY

Complete the separate 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.

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; **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 for whom the participant is legal guardian	A child for whom the participant is the legal guardian	Court order making member a guardian of another 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
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.	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 07/20

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.

NAME	EDISON ID	OR	SSN

Special Enrollment Qualifying Events

The federal law, Health Insurance Portability and Accountability Act (HIPAA), allows you and your dependents to enroll in health coverage under certain conditions, including acquiring new dependents and loss of health coverage offered through your spouse's or ex-spouse's employer. If you are adding dependents to your **existing** coverage, you and your dependents may transfer to a different carrier or healthcare option, if eligible. You or your dependents may also be eligible to enroll in dental and vision coverage when dental and vision coverage is lost with another employer. 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 apply to you and/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 insurance coverage or within 60 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.

QUALIFYING EVENT	DOCUMENTATION REQUIRED	EFFECTIVE DATE
☐ Death of spouse or ex-spouse	Copy of death certification and written documentation from the employer on company letterhead providing names of covered participants and date coverage ended	Day after loss of coverage **OR** first day of the month following loss of other coverage
☐ Divorce	Copy of the signed divorce decree and written documentation from the employer on company letterhead providing names of covered participants, date coverage ended and what coverage was lost (i.e., medical, dental, vision)	Day after loss of coverage **OR** first day of the month following loss of other coverage
☐ Legal separation	Copy of the agreed order of legal separation and written documentation from the employer on company letterhead providing names of covered participants, date coverage ended, reason why coverage ended and what coverage was lost (i.e., medical, dental, vision)	Day after loss of coverage **OR** first day of the month following loss of other coverage
☐ Loss of eligibility (does not include a loss due to failure to pay premiums or termination of coverage for cause)	Written documentation from the employer or the insurance company on company letterhead providing the names of covered participants, date coverage ended, reason for the loss of eligibility and what coverage was lost (i.e., medical, dental, vision)	Day after loss of coverage **OR** first day of the month following loss of other coverage
☐ Loss of coverage due to exhausting lifetime benefit maximum	Written documentation from the insurance company on company letterhead providing the names of covered participants, date coverage ended, stating that the lifetime maximum has been met and what coverage was lost (i.e., medical, dental, vision)	Day after loss of coverage **OR** first day of the month following loss of other coverage
☐ Loss of TennCare (does not include a loss due to failure to pay premiums)	Written documentation from TennCare providing the names of covered participants, date coverage ended and the reason why coverage ended	Day after loss of coverage **OR** first day of the month following loss of other coverage
☐ Termination of spouse's or ex-spouse's employment (voluntary and non-voluntary)	Written documentation from the employer on company letterhead providing names of covered participants, date coverage ended, reason why coverage ended and what coverage was lost (i.e., medical, dental, vision)	Day after loss of coverage **OR** first day of the month following loss of other coverage
☐ Employer eliminated contribution to spouse's, ex-spouse's or dependent's insurance coverage (total contribution, not partial)	Written documentation from the employer on company letterhead providing names of covered participants, date contribution amount changed, date coverage ended and what coverage was lost (i.e., medical, dental, vision)	Day after loss of coverage **OR** first day of the month following loss of other coverage
☐ Spouse's or ex-spouse's work hours reduced causing loss of eligibility for insurance coverage	Written documentation from the employer on company letterhead providing names of covered participants, date coverage ended, reason why coverage ended and what coverage was lost (i.e., medical, dental, vision)	Day after loss of coverage **OR** first day of the month following loss of other coverage
When a new dependent is acquired, a non-covered employee may use the event to enroll in employee only or family coverage. If the employee is already enrolled, they may add the new dependent and previously eligible dependents (those who were not enrolled when initially eligible and are otherwise still eligible). Required documentation is listed below. Employees only requesting to add a new dependent should follow regular enrollment procedures.		
☐ Acquires a new dependent — spouse	Copy of marriage certificate	Date of marriage **OR** first day of the month following marriage
☐ Acquires a new dependent — newborn	Copy of birth certificate for newborn	Date of birth
☐ Acquires a new dependent — adoption/ legal custody	Copy of adoption documents	Date of adoption or legal custody